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Social Security Disability Insurance Program

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UNITED STATES SENATE

ROBERT J. DOLE, *Chairman*

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I. INTRODUCTION

The social security disability insurance (DI) program is the Nation's largest disability-connected cash benefit program. Under the DI program and the supplemental security income program (which provides means-tested benefits), the Social Security Administration is responsible for nearly half of all benefit expenditures made from publicly financed disability programs. The Committee on Finance last reviewed the workings of the DI program in 1979, and subsequently acted on legislation to deal with the enormous growth that occurred in the 1970s. Numerous measures to address excessive benefit levels, work disincentives and apparent weaknesses in the administrative practices of the program were enacted in the Social Security Disability Amendments of 1980 (Public Law 96-265).

One of the administrative requirements of the 1980 legislation has been a particular source of recent attention to the program. This is the requirement that the eligibility of DI beneficiaries be reviewed at least once every 3 years. This provision was adopted in 1980 as a result of congressional concern over the lack of monitoring of the benefit rolls. Its implementation has resulted in the finding that significant numbers of individuals should be terminated from the social security disability rolls. This has highlighted questions concerning the adequacy of the determination process, the proper standards to be applied in determining whether an individual continues to qualify for benefits, and the appropriateness of applying what appear to be different concepts of disability at the initial and appellate levels of decisionmaking.

II. GENERAL BACKGROUND ON DISABILITY INSURANCE

The Social Security Administration (SSA) administers two national disability programs: the social security disability insurance (DI) program and the supplemental security income (SSI) program. The disability insurance program, by far the larger of the two programs, provides benefits to disabled workers (and their spouses and children) in amounts related to the disabled worker's former wages in covered employment. Funding is provided through the social security payroll tax, a portion of which is allocated to a separate disability insurance trust fund. The SSI program provides cash assistance to the needy aged as well as to the needy blind and disabled, many of whom do not have recent attachment to the labor force. As a needs-based program, SSI provides payments based on the amount of other income available to the individual. Unlike DI, SSI is funded through appropriations from general revenues.

A. Summary of Program Characteristics

Beneficiaries: The DI program is the Nation's primary source of income replacement for the families of workers who are unable to work due to a disabling condition. It has 4.4 million beneficiaries, 2.7 million of whom are disabled workers. Among workers awarded benefits in 1975, the median age was 55.6. Approximately 44 percent had been employed in blue-collar occupations requiring some type of physical labor, 60 percent had less than a high school education, 32 percent were women, and 15 percent were black. The leading causes of disability were: diseases of the circulatory system, 27 percent; diseases of the musculoskeletal system, 17 percent; mental disorders, 10 percent; and cancer, 10 percent.

TABLE 1.—PERCENT DISTRIBUTION OF DISABLED-WORKER BENEFICIARIES BY AGE AND SEX COMPARED WITH ADULT U.S. POPULATION, 1975

Characteristics	Disability beneficiaries	Adult U.S. population [1]
Total percent	100.0	100.0
Age:		
Under 35	11.0	43.0
35 to 44	10.0	20.0
45 to 54	26.0	21.0
55 to 59	23.0	9.0
60 and over	30.0	8.0
Median age (years)	55.6	38.6
Sex:		
Male	68.0	48.0
Female	32.0	52.0

[1] Derived from 1970 Census, based on population aged 18–64.

Source: Background material and data on major programs within the jurisdiction of the Committee on Ways and Means. Committee Print 97–29. Feb. 18, 1982.

There are 2.3 million SSI disability recipients, accounting for 59 percent of the overall SSI population. About two-thirds of new SSI awards are for disabled recipients.

Benefits: DI benefits are based on the worker's average monthly earnings prior to the onset of disability, indexed to reflect national wage growth. (Up to 5 years of low earnings are excluded.) The benefits are tax free and adjusted annually for increases in the cost of living. Benefits are also provided to dependents, subject to certain maximum family benefit limits. Currently, monthly benefits to newly disabled workers range up to $769 for the disabled worker, and up to $1,154 for the entire family. Benefits may be offset if the disabled-worker beneficiary is simultaneously receiving workers' compensation or other public disability benefits.

As of June 1982, the average monthly benefit for disabled workers was $443 and, for disabled workers with dependents, it was $851. (See Table 2 below.) The DI program cost $17.3 billion in fiscal year 1981 and, under current law, the Administration projects it will cost $18.4 billion in fiscal year 1982.[1]

TABLE 2.—DISABILITY INSURANCE CASH BENEFITS OVER TIME FOR DISABLED WORKERS AND THEIR DEPENDENTS

Calendar year [1]	Average monthly benefit			
	Disabled worker	Spouses	Children	Disabled-worker families
Current beneficiaries:				
1970	$131	$43	$39	272
1975	224	67	62	442
1981	414	122	111	809
1982	443	131	129	851
New awards:				
1970	139	40	37	(2)
1975	244	73	68	(2)
1981	439	117	125	(2)
1982	454	126	130	(2)

[1] As of June.

[1] Under 1982 OASDI Trustees' Report II-B assumptions.

[2] Not available.

Source: Office of the Actuary, SSA, July 1982.

Under SSI, there is a flat Federal payment standard of $284 monthly for an individual and $426 monthly for a married couple (which is supplemented by many States). As under the DI program, benefits are not taxable and are increased automatically each year to reflect changes in the cost of living. The actual payment to an individual is determined by the individual's other income—the greater his or her income, the lower the SSI payment. As of January 1982, disabled SSI recipients received an average payment of $217 a month. In fiscal year 1981, outlays for disabled SSI recipients were $4.8 billion and, under current law, the Administration projects they will reach $5.2 billion in fiscal year 1982.

Eligibility: To be eligible for DI benefits, a worker must be both "fully" and "disability" insured—that is, have credit for having worked in covered employment for a certain period of time. In 1982, a worker receives 1 quarter's credit for each $340 of annual earnings (up to a maximum of 4 quarters). To be fully insured for life, a worker must have credit for working 40 calendar quarters in covered employment. If a person has not worked 40 quarters, he is still fully insured if he has at least one quarter of coverage for each year after 1950, or if later, after the year in which he reached 21, and prior to the onset of disability. To be disability insured, the worker must have 20 quarters of coverage in the immediately preceding 40 quarters. (There are exceptions for younger workers and the blind.) Currently, more than 95 million people are insured in the event of disability.

Under the law, disability is defined as the inability to engage in substantial gainful activity by reason of a medically determinable physical or mental impairment expected to result in death or last at least 12 months. Generally, the worker must be unable to do any kind of work which exists in the national economy, taking into account age, education and work experience. Except in cases of second or subsequent disabilities, a person must be disabled continuously for a 5 full-month waiting period before he can receive DI benefits. (An individual whose disability begins in January would begin receiving benefits for the month of July.)

The SSI program generally uses the same criteria for determining disability. There are no prior work requirements, however, and no waiting period for benefits. Instead, the individual must meet a means test.

B. Financing Provisions

Like the social security retirement and survivors insurance and hospital insurance programs, the DI program is financed by the social security payroll tax on covered workers. Approximately 90 percent of the work force is covered by the system. The tax, which is paid equally by employees and employers, is levied on wages and self-employment earnings up to a maximum level established each calendar year. The total social security tax rate levied on the earnings of wage earners is 6.7 percent this year. This amount is paid by both the employee and employer so that the total tax rate on the earnings paid to workers is 13.4 percent. For the self-employed,

the social security tax rate is currently 9.35 percent. The maximum amount of earnings subject to the tax, referred to as the taxable earnings base, is $32,400 in 1982. (This amount rises each year at the same rate that average earnings in the economy rise.) When a worker's earnings reach this maximum level during the year, the tax is no longer withheld. Table 3 shows the social security tax rates and taxable earnings base under current law and how the overall tax is distributed among the three programs.

Currently, with a tax of 0.825 percent (employee-employer, each), the DI program receives about 11 percent of the overall social security tax receipts. When the ultimate social security tax rate goes into effect in 1990, the DI program, with a tax rate of 1.1 percent (employee and employer, each) will be allocated about 14 percent of overall receipts.

The DI program also receives income in the form of interest on the investments of its trust fund—now representing 2.3 percent of its total income—and small payments from the General Fund of the Treasury to reimburse for gratuitous wage credits granted to members of the armed services—representing less than 1 percent of the DI program's total income this year.[1]

[1] Based on the Intermediate II-B assumption in the 1982 OASDI Trustees' Report.

TABLE 3.—TAX RATES AND TAXABLE EARNINGS BASES, PAST AND FUTURE

Calendar Year	Taxable earnings base	Tax rate (percent)							
		Employer and employee, each				Self-employed persons			
		Total	OASI	DI	HI	Total	OASI	DI	HI
1937	$3,000	1.0	1.0	.....	.....	.....	.....	.....	.....
1950	3,000	1.5	1.5	.....	.....	.....	.....	.....	.....
1951	3,600	1.5	1.5	.....	.....	2.25	2.25	.....	.....
1954	3,600	2.0	2.0	.....	.....	3.0	3.0	.....	.....
1955	4,200	2.0	2.0	.....	.....	3.0	3.0	.....	.....
1957	4,200	2.25	2.0	0.25	.....	3.375	3.0	0.375	.....
1959	4,800	2.5	2.25	0.25	.....	3.75	3.375	0.375	.....
1960	4,800	3.0	2.75	0.25	.....	4.5	4.125	0.375	.....
1962	4,800	3.125	2.875	0.25	.....	4.7	4.325	0.375	.....
1963	4,800	3.625	3.375	0.25	.....	5.4	5.025	0.375	.....
1966	6,600	4.2	3.5	0.35	0.35	6.15	5.275	0.525	0.35
1967	6,600	4.4	3.55	0.35	0.5	6.4	5.375	0.525	0.5
1968	7,800	4.4	3.325	0.475	0.6	6.4	5.0875	0.7125	0.6
1969	7,800	4.8	3.725	0.475	0.6	6.9	5.5875	0.7125	0.6
1970	7,800	4.8	3.65	0.55	0.6	6.9	5.475	0.825	0.6
1971	7,800	5.2	4.05	0.55	0.6	7.5	6.075	0.825	0.6
1972	9,000	5.2	4.05	0.55	0.6	7.5	6.075	0.825	0.6
1973	10,800	5.85	4.3	0.55	1.0	8.0	6.205	0.795	1.0
1974	13,200	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1975	[1] 14,100	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1976	15,300	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1977	16,500	5.85	4.375	0.575	0.9	7.9	6.185	0.815	0.9
1978	17,700	6.05	4.275	0.775	1.00	8.10	6.01	1.09	1.00
1979	22,900	6.13	4.33	0.75	1.05	8.10	6.01	1.04	1.05

TABLE 3.—TAX RATES AND TAXABLE EARNINGS BASES, PAST AND FUTURE—Continued

Calendar Year	Taxable earnings base	Tax rate (percent)							
		Employer and employee, each				Self-employed persons			
		Total	OASI	DI	HI	Total	OASI	DI	HI
1980	25,900	6.13	4.52	0.56	1.05	8.10	6.2725	0.7775	1.05
1981	29,700	6.65	4.7	0.65	1.30	9.30	7.025	0.975	1.30
1982	32,400	6.70	4.575	0.825	1.30	9.35	6.8125	1.2375	1.30
Future schedule:									
1983	[2] 35,100	6.70	4.575	0.825	1.30	9.35	6.8125	1.2375	1.30
1984	[2] 37,500	6.70	4.575	0.825	1.30	9.35	6.8125	1.2375	1.30
1985	[2] 40,500	7.05	4.75	0.95	1.35	9.90	7.125	1.425	1.35
1986	[2] 43,800	7.15	4.75	0.95	1.45	10.0	7.125	1.425	1.45
1990 and thereafter	[2] 57,000	7.65	5.10	1.10	1.45	10.75	7.65	1.65	1.45

[1] Beginning in 1975, automatic increases, except 1978–81.

[2] Projections based on the intermediate II–B assumptions in the 1982 OASDI Trustees' Report. The actual taxable earnings base for calendar year 1983 and later will depend upon how much average wages rise in the economy from one year to the next.

C. Financial Status

While current projections of the financial condition of the social security system are adverse both in the near-term and long-term, the latest report of the social security board of trustees projects that the DI program, by itself, is in good financial shape and will remain so throughout the entire 75-year valuation period. Under all four sets of assumptions in the 1982 report, income to the DI trust fund is estimated to exceed expenditures in every year during the 1982–86 period.[2] In contrast to the old-age and survivors' insurance (OASI) program, which is expected to deplete available assets by June of 1983, the assets in the DI trust fund are projected to grow continuously, even under the trustees' pessimistic assumptions. The 75-year projections show sizable surpluses.

It would be shortsighted to view the DI program in isolation, however. Under the interfund borrowing authority provided by Congress in 1981 (Public Law 97–123), the DI trust fund must share its assets, or the receipts arising from the payroll tax, with the two other social security trust funds—OASI and HI (Hospital Insurance). The DI program's well-being pales in comparison to the adverse financial condition of the much larger OASI program. When these two programs are viewed jointly, the financial forecast for the social security program is poor both in the near-term and long-term. The growth of reserves in the DI program in the next five years would not be sufficient to offset the projected decline in the OASI trust fund, and the combined assets of the two trust funds would run out in late 1983 under all four sets of trustees' assumptions.

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[2] This does not reflect the fact that under the interfund borrowing authority enacted in P.L. 97–123, the OASI program will borrow substantial sums from the DI program this year, and thereby erode the reserve base of the DI program.

TABLE 4.—ESTIMATED OPERATIONS OF THE OASI, DI, AND HI TRUST FUNDS UNDER PRESENT LAW ON THE BASIS OF THE 1982 TRUSTEES' REPORT, CALENDAR YEARS 1981–91

[Amounts in billions, alternative II–B assumptions]

Calendar year	Income					Outgo				
	OASI	DI	OASDI	HI	Total	OASI	DI	OASDI	HI	Total
1981	$125.4	$17.1	$142.4	$35.7	$178.2	$126.7	$17.7	$144.4	$30.7	$175.1
1982 [1]	137.1	17.0	154.1	32.8	186.9	141.8	18.5	160.3	35.7	195.9
1983 [2]	137.0	26.1	163.1	42.2	205.4	156.4	19.1	175.5	41.6	217.1
1984	149.1	29.5	178.6	46.1	224.8	173.2	20.1	193.3	48.3	241.6
1985	167.1	37.3	204.5	51.5	256.0	191.1	21.5	212.5	55.6	268.1
1986	180.7	41.8	222.5	59.3	281.8	208.5	22.9	231.4	63.4	294.8
1987	194.3	46.3	240.5	63.7	304.3	226.4	24.3	250.8	72.1	322.9
1988	208.8	51.1	259.9	68.0	327.9	244.7	25.9	270.6	81.9	352.5
1989	223.5	56.2	279.8	72.1	351.8	263.4	27.7	291.1	92.6	383.7
1990	256.6	69.4	326.0	75.7	401.7	282.3	29.5	311.8	104.1	415.9
1991	275.2	76.5	351.7	79.0	430.7	300.9	31.4	332.3	116.8	449.1

Calendar year	Net increase in funds					Funds at end of year					Assets at beginning of year as a percentage of outgo during year				
	OASI	DI	OASDI	HI	Total	OASI	DI	OASDI	HI	Total	OASI	DI	OASDI	HI	Total
1981	−$1.3	−$0.6	−$1.9	$5.0	$3.1	$21.5	$3.0	$24.5	$18.7	$43.3	18	21	18	45	23
1982 [1]	−4.7	−1.5	−6.2	−2.9	−9.1	16.8	1.6	18.4	15.9	34.2	15	16	15	53	22
1983 [2]	−19.4	7.1	−12.3	.6	−11.7	−2.6	8.6	6.0	16.5	22.5	11	8	10	38	16
1984	−24.0	9.4	−14.6	−2.1	−16.8	−26.6	18.0	−8.6	14.4	5.7	−1	43	3	34	9
1985	−23.9	15.9	−8.0	−4.0	−12.1	−50.5	33.9	−16.7	10.3	−6.4	−14	84	−4	26	2
1986	−27.9	18.9	−8.9	−4.2	−13.1	−78.4	52.8	−25.6	6.2	−19.4	−24	148	−7	16	−2
1987	−32.2	21.9	−10.2	−8.4	−18.6	−110.6	74.7	−35.8	−2.2	−38.1	−35	217	−10	9	−6
1988	−35.9	25.2	−10.7	−13.9	−24.6	−146.5	99.9	−46.5	−16.1	−62.6	−45	288	−13	−3	−11
1989	−39.8	28.6	−11.3	−20.6	−31.9	−186.3	128.5	−57.8	−36.7	−94.5	−56	361	−16	−17	−16
1990	−25.7	39.9	14.2	−28.4	14.2	−212.0	168.4	−43.6	−65.1	−108.7	−66	436	−19	−35	−23
1991	−25.7	45.1	19.4	−37.8	−18.5	−237.7	213.5	−24.2	−102.9	−127.2	−70	536	−13	−56	−24

1. The income figures for 1982, and the end-of-year asset figures for 1982 and later, reflect the transfer of funds from the DI and HI Trust Funds to the OASI Trust Fund under the interfund borrowing authority provided by Public Law 97–123. Under this set of assumptions, a total of $11.1 billion would be transferred to OASI in 1982, $5.7 billion from DI and $5.3 billion from HI.

2. The estimated operations for OASI, OASDI, and OASDI and HI combined in 1983 and later are theoretical since, following the expiration of the present law interfund borrowing authority, the OASI Trust Fund would become depleted in July 1983 when assets would become insufficient to pay benefits when due. Similarly, the HI Trust Fund operations in 1987 and later are theoretical since the fund would be depleted in 1987 under this set of assumptions.

Source: Office of the Actuary, SSA, March 26, 1982.

Even if interfund borrowing were to be reauthorized beyond 1982 or another tax reallocation were enacted, the combined assets of the three trust funds are expected to be exhausted by 1984. Only the optimistic assumptions show the assets of the combined programs remaining above the insolvency point (assets equal to one month's benefits) in the near-term, and only barely so.

The long-term situation is similar, with only the optimistic assumptions in the trustees' report showing the OASDI programs as being actuarially solvent. Under the other three sets of assumptions, the surpluses in the DI trust fund are not nearly sufficient to offset the projected deficits in the OASI trust fund or those that would be projected in the HI trust fund. (75-year projections for HI are not normally made.) The following table shows the intermediate (II–B) projections for the OASI and DI programs.

TABLE 5.—LONG-RANGE OASDI FINANCIAL STATUS PROJECTIONS: INTERMEDIATE II–B ASSUMPTIONS

[As percent of taxable payroll]

Calendar years	Average tax rate	Estimated average cost rate	Difference
OASI:			
1982–2006	9.93	10.14	−0.21
2007–31	10.20	12.43	−2.23
2032–56	10.20	15.20	−5.00
1982–2056	10.11	12.59	−2.48
DI:			
1982–2006	2.07	1.23	.85
2007–31	2.20	1.65	.55
2032–56	2.20	1.61	.59
1982–2056	2.16	1.50	.66
OASI AND DI:			
1982–2006	12.01	11.37	.64
2007–31	12.40	14.06	−1.68
2032–56	12.40	16.81	−4.41
1982–2056	12.27	14.09	−1.82

Source: 1982 OASDI Trustees' Report.

NOTE: HI excluded because projections in Trustees' Report are only made for 25-year period. In terms of 1982 payroll, 1 percent of payroll is equivalent to an average deficit or surplus of almost $14 billion annually.

TABLE 6.—LONG-RANGE OASDI TRUST FUND RESERVE RATIOS: INTERMEDIATE II–B ASSUMPTIONS

[Start-of-year assets as percent of outgo]

Calendar year	OASI	DI	Total
1982	15	16	15
1983	11	8	10
1984	(1)	43	3

TABLE 6.—LONG-RANGE OASDI TRUST FUND RESERVE RATIOS: INTERMEDIATE II–B ASSUMPTIONS—Continued

[Start-of-year assets as percent of outgo]

Calendar year	OASI	DI	Total
1985	(1)	84	−4
1986	(1)	148	−7
1987	(1)	217	−10
1988	(1)	266	−13
1989	(1)	361	−16
1990	(1)	436	−19
1991	(1)	536	−13
1992	(1)	631	−7
1993	(1)	723	(2)
1994	(1)	812	7
1995	(1)	895	15
1996	(1)	959	23
1997	(1)	1,019	32
1998	(1)	1,076	42
1999	(1)	1,130	53
2000	(1)	1,178	64
2001	(1)	1,227	76
2002	(1)	1,270	89
2003	(1)	1,303	102
2004	(1)	1,327	115
2005	(1)	1,332	128
2006	(1)	1,366	140
2010	(1)	1,435	177
2015	(1)	1,549	177
2020	(1)	1,703	125
2025	(1)	1,938	31
2030	(1)	2,241	(1)
2035	(1)	2,504	(1)
2040	(1)	2,693	(1)
2045	(1)	2,837	(1)
2050	(1)	3,061	(1)
2055	(1)	3,330	(1)
2060	(1)	3,582	(1)
Trust fund is projected to be first exhausted in	1983		1983

[1] The fund is projected to be exhausted and not to recover before the end of the projection period.
[2] Less than 0.5 percent.

Source: 1982 OASDI Trustees' Report.

As shown in Table 5, the cash benefit programs have, over the next 75 years, a deficit of 1.82 percent of payroll.[3] This means that—under the actuaries' best current estimates—social security taxes would have to be increased by a combined 1.82 percentage points (or $25 billion in 1982 terms) for each of the next 75 years. This (again in 1982 terms) represents a total deficit of $1.9 trillion over the next 75 years.

If the deficit in the OASDI program is not addressed in the near-term, it becomes substantially larger on an annual basis in the future. For the last one-third of the 75-year period, an average annual deficit of 4.41 percent of taxable payroll (over $60 billion per year in 1982 terms) is projected. Taking account of HI, the social security system deficit would be substantially higher.

It should be noted that the good financial state of the DI program, by itself, is not solely the consequence of favorable or lower than anticipated enrollment and expenditures. In the past few years overall enrollment in the program has fallen very noticeably below the estimates made when the last major financing provisions were enacted in 1977. However, those amendments increased overall payroll taxes and made a very substantial reallocation of the overall tax to the DI program. The tax increase and reallocation between the trust funds were deliberately large because of the rapid growth in the program and uncertainty among the social security actuaries about trends for the future. No steps were taken in those amendments to address the unexpected and rapid growth of the program over the 10 or more years preceding the amendments.

It is also important to view the favorable financial condition of the DI program cautiously given that the incidence of disability has shown volatility over the last 25-years. The rate of awards per thousand persons insured for DI (shown in Chart 1) has varied between 3.6 and 7.1, with the lowest rates experienced recently. Future cost projections, of course, are largely based on recent experience.

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[3] In 1982, total taxable payroll will amount to $1.361 trillion (under Trustees' intermediate II-B assumptions).

CHART 1

DISABILITY INSURANCE PROGRAM

AWARDS PER THOUSAND INSURED WORKERS

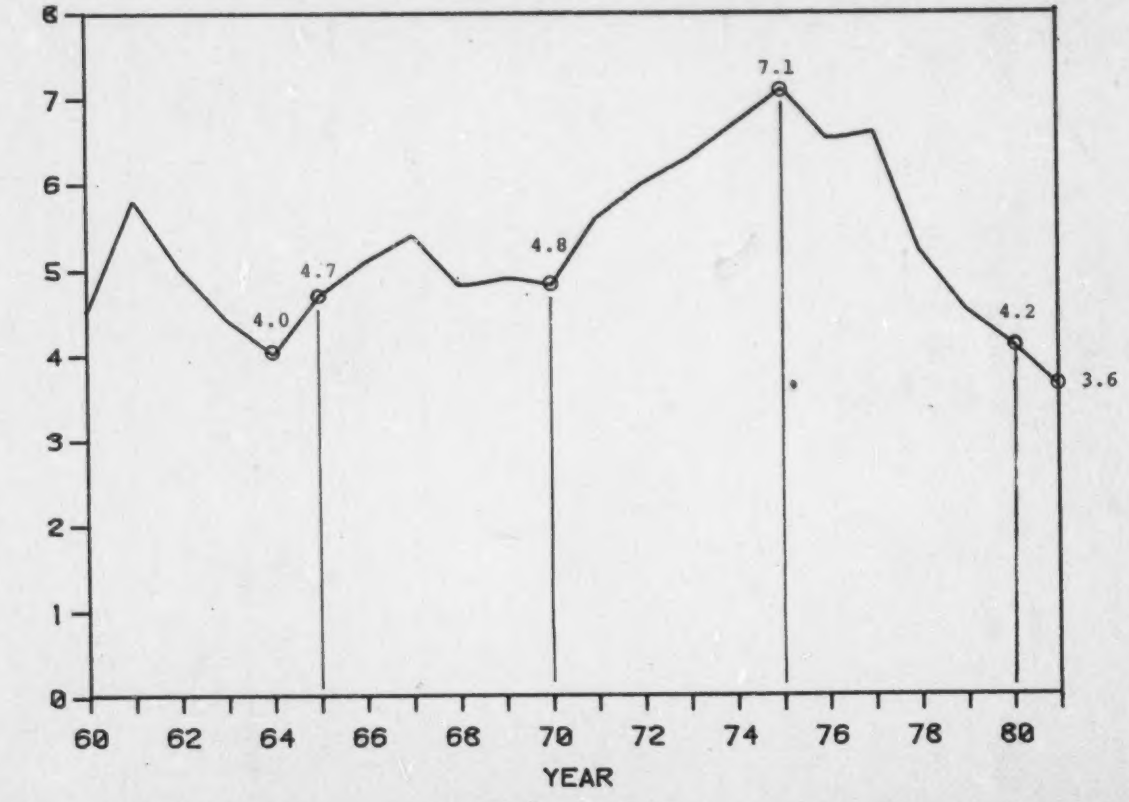


TABLE 7.—PERSONS INSURED FOR DI AND RATES OF DISABILITY, 1960–81

Calendar year [1]	Persons insured for DI (in millions)	Awards per 1,000 insured workers
1960	46.4	4.5
1961	48.5	5.8
1962	50.5	5.0
1963	51.5	4.4
1964	52.3	4.0
1965	53.3	4.7
1966	55.0	5.1
1967	55.8	5.4
1968	68.0	4.8
1969	70.1	4.9
1970	72.4	4.8
1971	74.5	5.6
1972	76.1	6.0
1973	77.8	6.3
1974	80.4	6.7
1975	83.3	7.1
1976	85.3	6.5
1977	87.0	6.6
1978	88.8	5.2
1979 [2]	91.1	4.5
1980 [2]	93.1	4.2
1981 [2]	95.2	3.6

[1] January 1 of each year.
[2] Preliminary.

Source: Office of Actuary, SSA.

III. GROWTH OF THE PROGRAM

A. Context for the Current Situation

The enactment of the disability amendments in 1980 marked the culmination of congressional interest in the social security disability programs that had been building since the mid-1970s. It was driven, for the most part, by three concerns: rapid increases in costs, work disincentives, and poor administration.

Probably foremost was the concern over the rapidly rising cost of the system, illustrated in Chart 2. Originally, the DI program was financed with a combined tax rate on the employee and the employer of ½ percent of taxable earnings. After numerous legislated liberalizations and a period of expansive enrollment, the combined tax rate more than doubled by 1980, reaching 1.12 percent, and is currently scheduled to rise to an ultimate rate of 2.2 percent—nearly 4½ times the original cost of DI. When the 1980 amendments were enacted, the annual cost of the system had risen from $3.3 billion in 1970 to $15.8 billion in 1980.

With the exception of the experience of the past few years, the DI program was plagued by a history of underfinancing almost since its inception. Over the 25-year life of the program, 1957 to 1981, the trustees reported a long-term financing deficiency on 15 separate occasions. On some six occasions Congress had to take steps to increase the amount of tax revenues going to the program. (See Appendix A for more on this.)

The second concern was that rising benefit levels and other aspects of the program had created barriers and disincentives for beneficiaries to attempt to return to work. As discussed in this section, a series of benefit increases in the late 1960s and early 1970s led to a marked increase in the amount of pre-disability earnings replaced by social security benefits and, therefore, to an increase in the number of people who could gain financially by coming onto, and remaining on, the DI rolls. (See Section III C for more on this.)

Finally, there was concern over repeated allegations that the program suffered from administrative failings. It was argued (and still is) that the decision-making process did not render uniform and equitable decisions from one applicant or beneficiary to another; that oversight of the State disability determination services and Administrative Law Judges (the principal entities making decisions about the existence of a disability) had not been sufficient to avoid a loosening of the standards of eligibility; and that there was not enough followup of the disabling conditions of beneficiaries after they joined the benefit roster.

CHART 2

DISABILITY INSURANCE PROGRAM

TOTAL COSTS

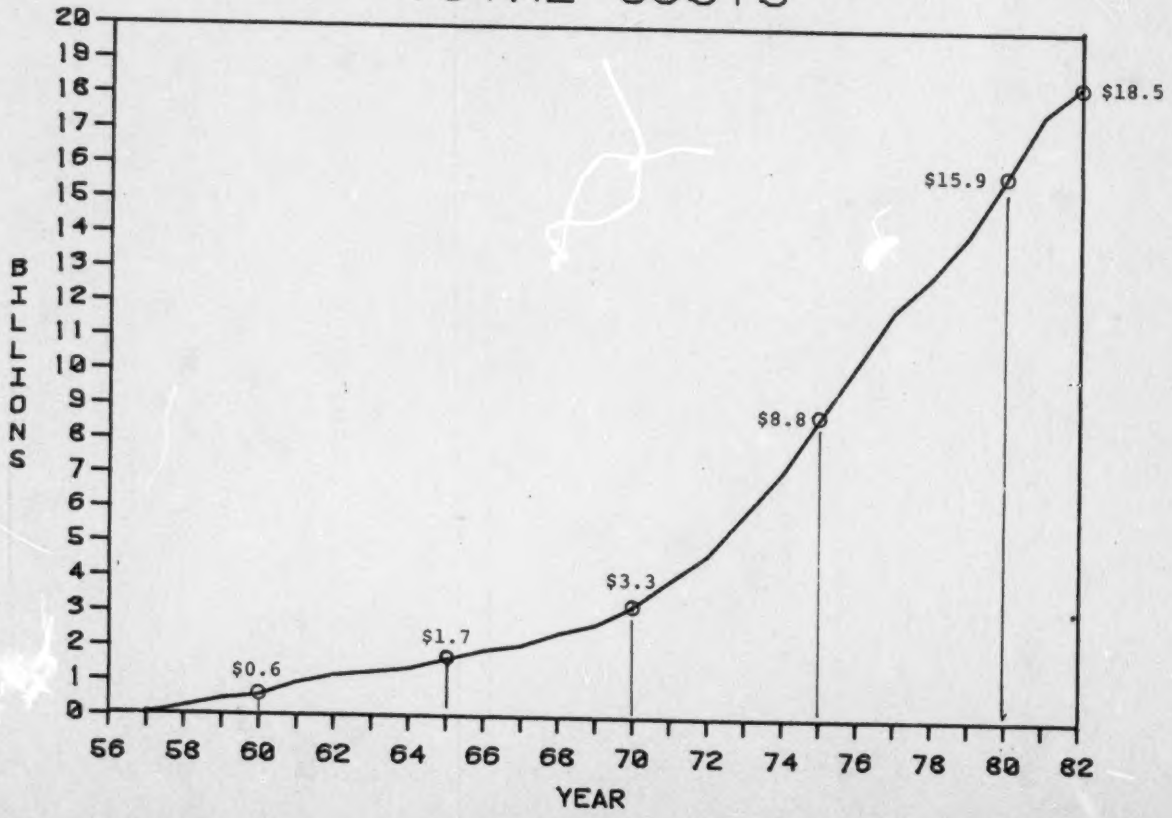


TABLE 8.—DISABILITY INSURANCE PROGRAM COSTS, 1957–82

[In millions]

Calendar year	Total costs
1957	$59
1958	261
1959	485
1960	600
1961	956
1962	1,183
1963	1,297
1964	1,407
1965	1,687
1966	1,947
1967	2,089
1968	2,458
1969	2,716
1970	3,259
1971	4,000
1972	4,759
1973	5,973
1974	7,196
1975	8,790
1976	10,366
1977	11,946
1978	12,954
1979	14,186
1980	15,872
1981	[1] 17,658
1982	[1] 18,508

[1] Estimated based on the Alternative II–B assumptions contained in the 1982 OASDI Trustees' Report.

Source: Social Security Bulletin, Annual Statistical Supplement, 1980.

While these three concerns overlapped, the growth of the program was certainly the most visible, and the one which exerted the greatest pressure on Congress to review the workings of the DI program. Congress addressed the unanticipated growth with the enactment of the Social Security Disability Amendments of 1980 (Public Law 96–265). This legislation was intended to constrain the growth of the DI program, provide more control over the size of the beneficiary caseload, and improve program incentives for rehabilitation and return to work.

Of the numerous administrative measures included in the amendments, probably the most significant were those intended to: (1) invigorate the Social Security Administration's oversight of the State disability determination services, and (2) revive and revitalize

procedures to ensure the continuing eligibility of people receiving DI benefits.

Importantly, the measures now being taken by SSA to bring greater control into its administrative processes, and consequently over the caseload of the DI program, are not random, isolated, and unintended steps. They are the direct result of recent legislation and half a decade or more of congressional oversight.

B. Growth Pattern of the Benefit Rolls

For most of the history of the DI program, the growth in the number of DI beneficiaries paralleled the growth in expenditures. The benefit rolls showed quite dramatic growth up through the mid-1970s. Only recently has there been a reversal of trends. Standing at 4.9 million people in 1978, the benefit rolls are now declining. This is illustrated in Table 9 below.

TABLE 9.—DI BENEFICIARIES, YEAR-BY-YEAR, 1957–82

Calendar year	Disabled workers	Total DI beneficiaries [1]
1957	149,850	149,850
1958	237,719	268,057
1959	334,443	460,354
1960	455,371	687,451
1961	618,075	1,027,089
1962	740,867	1,275,105
1963	827,014	1,452,472
1964	894,173	1,563,366
1965	988,074	1,739,051
1966	1,097,190	1,970,322
1967	1,193,120	2,140,214
1968	1,295,300	2,335,134
1969	1,394,291	2,487,548
1970	1,492,948	2,664,995
1971	1,647,684	2,930,008
1972	1,832,916	3,271,486
1973	2,016,626	3,558,982
1974	2,236,882	3,911,334
1975	2,488,774	4,352,200
1976	2,670,208	4,623,757
1977	2,837,432	4,860,431
1978	2,879,774	4,868,490
1979	2,870,590	4,777,412
1980	2,861,253	4,682,172
1981	2,776,519	4,456,274
1982 est.[2]	2,723,000	4,374,000

[1] Includes spouses and children of disabled workers.

[2] 1982 OASDI Trustees' Report, Intermediate II–B assumptions.

Source: Social Security Bulletin, annual statistical supplement, 1980.

Experience through the late 1970's.—In 1960, four years after DI benefits first became available, 208,000 disabled workers were awarded benefits. Fifteen years later, the number of new awards had grown to 592,000—almost three times the number made in 1960. From the inception of the program through the end of 1981, approximately 8,728,000 disabled workers joined the benefit rolls, some 5,569,000 of whom came on during the 1970–81 period. In other words, about 64 percent of those who have received benefits from the DI program came on during a period which began 14 years after the program was introduced. The heaviest period of growth was from 1970 to 1977, when the number of disabled workers on the rolls almost doubled—from 1.5 million to 2.9 million.

More Recent Experience.—The upward spiral in the number of people joining the DI rolls has been interrupted in recent years. Since 1975, in fact, the number of new awards made annually to disabled workers has dropped, after reaching an all time high of 592,000 in that year. Since then, the number of new awards to disabled workers has fallen to the point that the annual rate is now running at well under 400,000, as illustrated in Table 10 below. Similarly, the number of awards per thousand insured workers peaked in 1975 at 7.1, falling to an estimated 3.6 in 1982.

Complementing this has been a recent increase in the number of persons terminated from the rolls due to recovery. From 1967 to 1976, the number of beneficiaries leaving the rolls because they were found to have recovered medically, or to have been rehabilitated or able to return to work fluctuated relatively little, from 37,000 to 40,000 per year. In 1977, however, the number of beneficiaries determined to have recovered jumped to 60,000, and in 1979, the figure reached 72,325. This is illustrated in Table 11.

TABLE 10.—DI APPLICATIONS, AWARDS, AND ALLOWANCE RATES OVER TIME

Calendar year	Applications received in district offices [1] (thousands)	New disabled-worker awards (thousands)	Allowance rate [2] (in percent)	Total new awards [3] (thousands)
1969	725.1	344.7	48	753.1
1970	868.2	350.8	40	763.2
1971 [4]	924.4	415.9	45	901.3
1972	947.8	455.4	48	991.6
1973	1,066.9	491.6	46	1,033.6
1974	1,330.2	536.0	40	1,111.9
1975	1,267.2	592.0	47	1,256.0
1976 [4]	1,232.2	551.5	45	1,210.7
1977	1,235.2	[5] 569.0	46	1,239.4
1978	1,184.7	464.4	39	1,045.5

TABLE 10.—DI APPLICATIONS, AWARDS, AND ALLOWANCE RATES OVER TIME—Continued

Calendar year	Applications received in district offices [1] (thousands)	New disabled-worker awards (thousands)	Allowance rate [2] (in percent)	Total new awards [3] (thousands)
1979	1,222.6	408.7	33	921.2
1980	1,390.0	389.2	28	884.0
1981	1,234.8	345.3	30	787.3

[1] About 7 percent of the applications do not require a determination.
[2] Allowance rate is defined here as total awards divided by total applications.
[3] Awards to workers and their dependents combined.
[4] 1971 and 1976 contained 53 report weeks; all other years contain 52 report weeks. Awards are reported for 12 calendar months.
[5] It appears that a probable shortening of processing lags between allowance and award due to improvements in the automated claims processing system resulted in processing a substantial number of awards in 1977 that otherwise would have been processed in 1978.

Source: SSA, ORS, July 1982.

TABLE 11.—DI WORKER TERMINATIONS FROM THE ROLLS, 1957–79

Year	Total DI worker beneficiaries (in thousands)	Number of terminations		Gross termination rates (per thousand beneficiaries)		
		Death	Recovery [1]	Death	Recovery [1]	Death or recovery
1957	81	8,931	52	110.1	0.6	110.7
1958	201	28,099	1,397	152.2	7.6	159.8
1959	289	42,771	3,228	136.7	10.3	147.0
1960	397	43,543	3,124	109.6	7.9	117.5
1961	540	60,538	2,936	112.1	5.4	117.5
1962	684	67,020	9,555	97.9	14.0	111.9
1963	790	73,344	12,931	92.9	16.4	109.3
1964	867	75,812	16,487	87.5	19.0	106.5
1965	948	79,823	18,441	84.2	19.4	103.6
1966	1,053	84,399	23,111	80.1	21.9	102.0
1967	1,159	92,084	37,151	79.5	32.1	111.6
1968	1,259	99,924	37,723	79.4	30.0	109.4
1969	1,360	108,762	38,108	79.9	28.0	107.9
1970	1,460	105,799	40,802	72.5	27.9	100.4
1971	1,586	109,883	42,981	69.3	27.1	96.4
1972	1,754	108,663	39,393	62.0	22.5	84.5
1973	1,937	125,582	36,696	64.8	18.9	83.7
1974	2,129	135,083	[2] 38,000	63.4	[2] 17.8	[2] 81.2
1975	2,391	139,809	[2] 39,000	58.5	[2] 16.3	[2] 74.8

TABLE 11.—DI WORKER TERMINATIONS FROM THE ROLLS, 1957–79—Continued

Year	Total DI worker beneficiaries (in thousands)	Number of terminations		Gross termination rates (per thousand beneficiaries)		
		Death	Recovery[1]	Death	Recovery[1]	Death or recovery
1976	2,615	137,141	[2] 40,000	52.5	[2] 15.3	[2] 67.8
1977	2,781	139,418	[2] 60,000	50.1	[2] 21.6	[2] 71.7
1978	2,882	140,620	64,144	48.8	22.3	71.1
1979	2,893	143,023	72,325	49.4	25.0	74.4

[1] Recovery means medical improvement or return to work.

[2] Numbers of recovery terminations have been estimated for years 1974 through 1977 on the basis of data from other sources.

Source: Experience of Disabled Worker Beneficiaries under OASDI, 1974–78, Actuarial Study No. 81, April 1980.

Note: Subsequent discussions with SSA indicate that while the general trend of the data shown in the above table is fairly reliable, data assimilation problems have been found.

The combined effect of this lower number of awards and greater number of terminations due to recovery has been a decline in the number of persons on the rolls. The number of disabled workers on the rolls hit an all-time high of 2.881 million in July 1979. As of February 1982, the number stood at 2.745 million, indicating that the number of disabled workers on the rolls has declined by 135,000 in the last 2½ years. Similarly, the total number of beneficiaries on the rolls (disabled workers and their dependents combined), has fallen by almost 500,000 persons from its high of 4.872 million persons in September 1978 to 4.386 million in February 1982.

Charts 3 and 4 show the historical trends in DI application rates and allowance rates.

CHART 3

DISABILITY INSURANCE PROGRAM

APPLICATIONS PER THOUSAND INSURED WORKERS

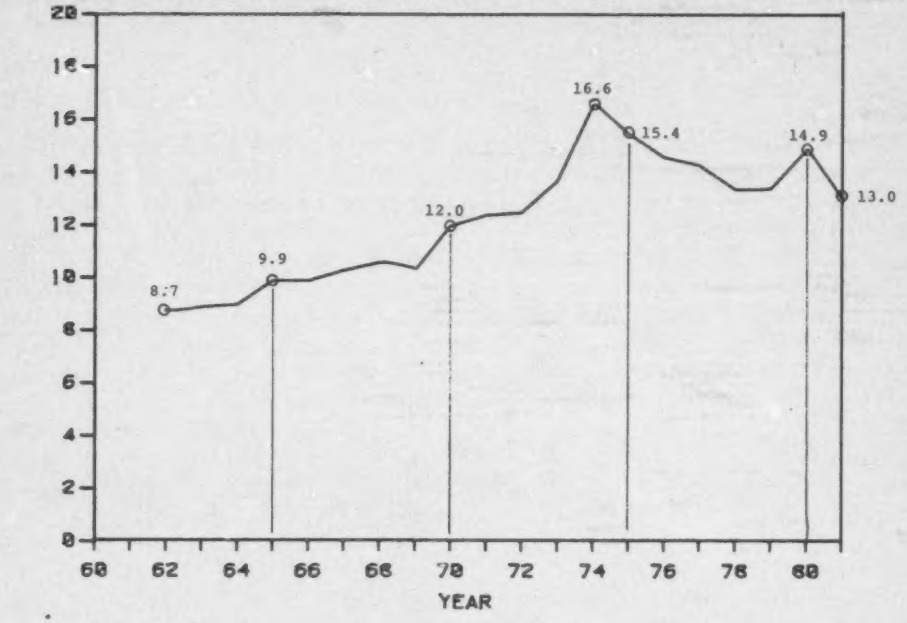
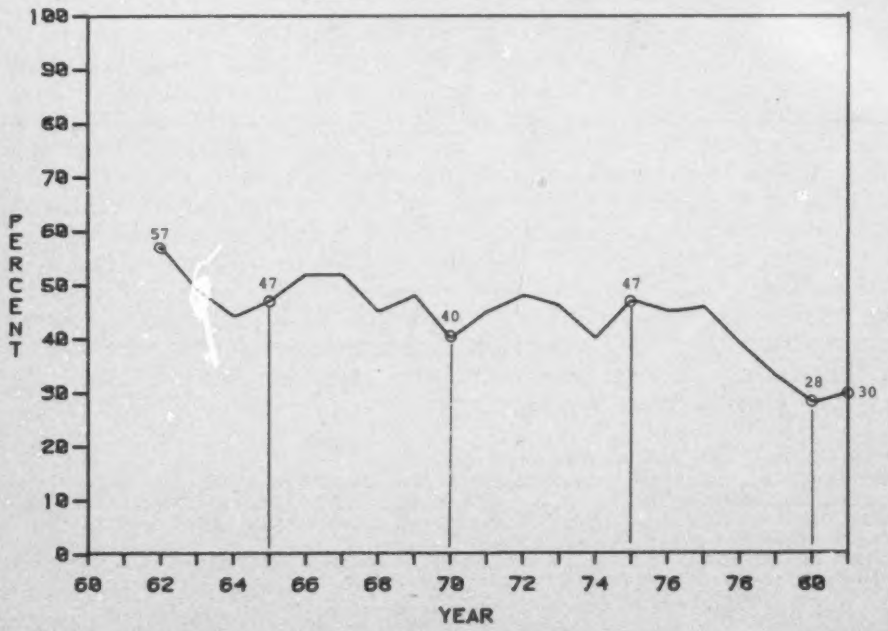


CHART 4

DISABILITY INSURANCE PROGRAM

ALLOWANCE RATE



Notwithstanding these changes in the DI beneficiary rolls, program costs will continue to be a concern. They are expected to continue to rise at a rapid rate, from $18.5 billion this year to an estimated $24 billion in 1986, due almost entirely to the effects of the economy on benefit levels.[4] Benefit costs and inflation are closely related since automatic benefit increases are tied to the CPI (since 1975).

C. Causal Factors for Growth and Later Contraction

As highlighted in the preceding discussion, the DI program experienced rapid growth through the early 1970s. There is still no consensus on exactly why that happened or even whether the period of rapid growth is over. The following factors are frequently cited for having contributed to the growth and later contraction.

Awareness: Some have suggested that increased awareness of the DI program was a contributing factor to growth. Findings from 1966 and 1972 Surveys of the Disabled, conducted by the Office of Research and Statistics of SSA, tend to confirm that public knowledge of the program did increase during the period between the two surveys.[5] The introduction of the SSI program in 1974 may have been important in this regard. There were significant outreach efforts initiated by SSA and public interest groups, intended to let the needy elderly and disabled know of the new SSI program. Also, SSI recipients are required by law to file dual applications for SSI and DI benefits.

It is interesting to note that more applications for DI benefits were filed in 1974 than in any other year in the history of the program. The number of DI applications increased from 1.1 million in 1973 to over 1.3 million in 1974, which is about the same number that is expected to be filed this fiscal year. The rate of applications per thousand insured workers in the population grew throughout the early 1970s and remained some 30 to 40 percent higher in the post-SSI implementation years than the rate that existed in the 1965 to 1970 period.

High benefit levels: Another factor affecting the decision to apply for benefits was the increase which occurred in the relative size of DI benefits. Benefits increased substantially in the early to mid 1970s not only in absolute terms, but also in terms of the amount of earnings they replaced (i.e., the ratio of the disabled worker's initial benefit to his earnings before becoming disabled). A study by the Office of Research and Statistics of SSA shows that the ratio of the average benefit awarded to the worker relative to his pre-disability earnings rose from 51 percent in 1969 to 59 percent in 1975. Further, the study showed that "one fourth of those entitled in 1969 had replacement rates of 80 percent of their previous earnings, but in 1975 this proportion had increased to 31 percent. In fact, one-fourth of the newly entitled received more in benefits than they earned while working."[6]

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[4] Under Trustees' intermediate II-B assumptions.

[5] U.S. Department of Health, Education, and Welfare. Social Security Administration. Office of Research and Statistics. The Growth in the Observed Disability Incidence Rates 1967-74. Prepared by Mordechai E. Lando and Aaron Krute. Presented at the Annual Meeting of the American Public Health Association, Oct. 19, 1976, p. 3.

[6] Lando, Mordechai E., Malcolm B. Coate, and Ruth Krans. Disability Benefit Applications and the Economy. Social Security Bulletin, V. 42, No. 10, Oct. 1979. p. 6.

Another study by the actuaries revealed that the average replacement rate for a worker (with dependents) with median earnings increased from about 60 percent in 1967 to 90 percent in 1976 (as measured by the ratio of family benefits to the worker's after-tax earnings in the year before the onset of disability.) [7] While different periods of measure and family composition were used and different replacement values resulted, both studies point to a significant increase in replacement rates over the period in which enrollment in the program grew most rapidly.

Further analysis supplied to the Finance Committee in 1979 by the Congressional Budget Office tended to confirm the existence of very high earnings replacement among families of disabled workers. (These findings are presented in tabular form in Appendix D.)

The value of benefits was also increased by the introduction of Medicare coverage for DI beneficiaries in 1972. Medicare benefits are provided after a DI beneficiary has been on the cash benefit rolls for 24 consecutive months. It was estimated in 1980 that the value of Medicare protection to the DI beneficiary averaged more than $100 per month. While a DI applicant may not place great weight on the value of Medicare at the time he makes his decision to apply, since he must wait 24 months to receive the protection, the loss of Medicare coverage for someone leaving the rolls may pose a very serious consideration, particularly if there is any question about obtaining private health insurance.

Termination rate: The increase in benefit levels and the introduction of Medicare coverage suggest another factor contributing to growth, namely a decline in the termination rate. As illustrated in Table 11, a declining percentage of beneficiaries left the rolls each year through the mid 1970s. Much of this was due to a decline in the rate of beneficiary deaths and the rate of conversions to the retirement rolls as a greater number of younger and less severely disabled persons joined the DI rolls.[8] However, the rate of terminations due to recovery, return to work, or rehabilitation also declined in the late 1960s and early 1970s. In 1967, when there were some 1.1 million disabled workers on the rolls, 37,000 beneficiaries recovered and were terminated; yet in 1975, when there were 2 million disabled workers on the rolls only 39,000 recovered. The recovery rate actually declined from 32 persons per thousand beneficiaries in 1967 to a rate of slightly more than 16 persons per thousand beneficiaries in 1975.[9] It has been suggested that these adverse trends resulted from the fact that the incentives to leave the benefit rolls were eroded by the rising value of cash benefits and the concern about the loss of health insurance protection.

Lax administration in the early and mid 1970s: Still another factor contributing to the growth may have been lax administration. Because of large new workloads, perhaps pressure was placed

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[7] U.S. Dept. of Health, Education, and Welfare. Social Security Administration. Office of the Actuary. Experience of Disabled Worker Benefits under OASDI, 1965-74. Washington, Jan. 1977.

[8] The 1960 Social Security Amendments authorized DI benefits for disabled workers under age 50. The 1965 Amendments liberalized the definition of disability to permit persons into the program whose disabilities were expected to last as few as 12 months, instead of "indefinitely" as required under prior law.

[9] Treitel, Ralph. Recovery of Disabled Beneficiaries. A Followup Study of 1972 Allowances. Social Security Bulletin, Vol. 42, No. 4, April 1979, p. 5.

on SSA during the early 1970s to make disability determinations as quickly as possible. It has been suggested that this may have caused an unintended loosening of the definition of disability; allowing borderline disabled persons into the program; and permitting many others who had recovered to stay on. (On the other hand, speed today is claimed, by some, to be leading to a more restrictive definition of disability.)

Prior to 1972, more than 70 percent of the disability determinations made by the State disability determination agencies were reviewed by Federal examiners to verify their correctness. The other 30 percent were screened out as low-risk cases. This review process occurred before a final decision was rendered—it was called pre-effectuation review. Yielding to budget pressures, SSA adopted a sample review process in 1972 after which only 5 percent of allowances were subjected to this review, and then only after the beneficiaries had begun to receive benefits. Whereas in the late 1960s, approximately 10 percent of all beneficiaries were reviewed each year to ascertain whether or not they continued to be eligible, in the first half of the 1970s, only about 4 percent were investigated annually. This lessening of administrative efforts to assure accuracy of the rolls coincided with the period of rapid program growth.

SSA actuaries attempted to assess the reasons for the increase in disability incidence rates in a report published in 1977. Their analysis pointed to a variety of factors, including increases in benefit levels, high unemployment rates, changes in attitudes of the population, and administrative factors. They stated: "We feel that some administrative factors must have also played an important part in the recent increases, but we cannot offer a definite proof to that effect."

One administrative factor mentioned by the actuaries is the multistep appeals process, which enables the claimant to pursue his case to what the actuaries term the "weak link" in the hierarchy of disability determinations. Under the multistep appeals process, a claimant who has been denied benefits may request first a reconsideration, then a hearing before an administrative law judge, then an appeal of his hearing denial before the Appeals Council, and, if his case is still denied, he may take his claim to the U.S. district court. The actuaries claim that by the very nature of the claims process, the cases which progress through the appeals process are likely to be borderline cases where vocational factors play an important role in the determination of disability.

The definition of disability—"inability to engage in any substantial gainful activity by reason of a medically determinable impairment"—involves two variables: (1) impairment and (2) vocational factors. An emphasis on vocational factors, say the actuaries, citing William Roemmich, former Chief Medical Director of the Bureau of Disability Insurance, can change the definition to "inability to engage in usual work by reason of age, education, and work experience providing any impairment is present." To the extent that vocational factors are given higher weight as a claim progresses through the appeals process, the chances of reversal of a former denial are increased.

Also cited by the actuaries as one of the administrative factors which may have been responsible for the growth in the rolls was

the "massive nature" of the disability determination process. In fiscal year 1969, the Social Security Administration took in over 700,000 claims for DI benefits. By 1974 the number of DI claims per year had grown to 1.3 million. The number of SSI disability claims approached another million. In addition, there were over 500,000 disability claims under the black lung program, which started during 1970. As the actuaries point out, all of this was happening at a time the Administration was making a determined effort to hold down administrative costs. The actuaries stated:

> All of this put tremendous pressure on the disability adjudicators to move claims quickly. As a result the administration reduced their review procedures to a small sample, limited the continuing disability investigations on cases which were judged less likely to be terminated, and adopted certain expedients in the development and documentation in the claims process. Although all of these moves may have been necessary in order to avoid an unduly large backlog of disability claims, it is our opinion that they had an unfortunate effect on the cost of the program.

A final factor given for the increase in the disability incidence rates was "the difficulty of maintaining a proper balance between sympathy for the claimant and respect for the trust funds in a large public system." The actuaries maintain that they do not mean that disability adjudicators consciously circumvent the law in order to benefit an unfortunate claimant. Rather they mean that in a program designed specifically to help people, whose operations are an open concern to millions of individuals, and where any one decision has an insignificant effect on the overall cost of the program, there is a natural tendency to find in favor of the claimant in close decisions. "This tendency is likely to result in a small amount of growth in disability incidence rates each year, such as that experienced under the DI program prior to 1970, but it can become highly significant during long periods of difficult national economic conditions."

More recent contraction in the DI rolls

In recent years, an increase in the denial rate for new applicants and in the number of persons terminated has brought about a decline in the number of persons on the rolls.

Tighter administration.—This shift has been attributed by some program analysts to SSA's subtle but distinct emphasis since 1976 on improving the quality of disability decisions. In this regard, it is worth noting a subsequent actuarial study ("Experience of Disabled Worker Benefits Under OASDI, 1974–1978," Actuarial Study No. 81, April 1980) in which the author states:

> The nature and extent of SSA central office review of State agency initial disability determinations has been subject to frequent change in the past. Prior to 1972, 100 percent of initial determinations were reviewed before adjudication.* In 1972 the rate of review was limited to 5 per-

*In practice, a number of screening devices had permitted SSA to reduce the percent of cases requiring review—program officials believe that about 70 percent of cases were being reviewed in 1972.

cent of initial determinations. Subsequently, in order to reduce delays in processing time, review was made after adjudication. The author believes that these changes in review procedures have contributed to higher incidence rates since 1972. In 1977, however, the criteria upon which initial determinations are returned to State agencies were expanded. While the review is still postadjudicative and is only based on a small sample of initial determinations, the number of cases returned to State agencies has increased significantly. Presumably this increased feedback has contributed significantly to the decrease in incidence rates experienced since 1976. This trend toward more uniform standards and closer central office review is expected to result in a lower level of variation in the quality of disability determinations among the various State agencies, thus leading to smaller fluctuations in the DI program experience.

In 1979, the Ways and Means Committee Report on H.R. 3236, the Disability Amendments of 1980, referred to new assumptions of reduced disability incidence rates being used for actuarial estimates of DI costs, stating that the Subcommittee on Social Security had "received considerable testimony that this may be the result of tighter administration and a growing reliance on the medical factors in the determination of disability."

In the same year, the Social Security Subcommittee staff requested administrators of the State agencies to give their "opinion as to the reasons for these recent trends. . . . and deal with any other aspect of the 'climate of adjudication' which seems relevant to our inquiry." According to the staff analysis, administrators generally pointed to the promulgation of more specific Federal guidelines and better documentation of cases (as the result of quality assurance requirements and procedures) as being responsible for increased denials. Nearly all the administrators pointed to the elimination in July 1976 of the requirement that "medical improvement" had to be shown before the State agency could terminate a case. The need to show medical improvement had long been cited as a problem because some administrators felt that they were being forced by that requirement to continue people on the rolls who should not have been awarded benefits in the first place. Finally, some administrators suggested that criticism of the DI program had altered the "adjudicative climate."

If, indeed, tighter administration of the DI program is responsible for much of the recent slow-down in the growth of the benefit rolls, it may yet be too soon to conclude that the program's growth is under control. Administrative factors are highly volatile over time, as the experience of the 1970s would indicate.

IV. THE DISABILITY AMENDMENTS OF 1980

In 1980, Congress responded to the rapid growth of the DI program, the apparent work disincentives that had evolved, and allegations of growing weaknesses in the administration of the program, passing the most significant disability legislation since 1967—Public Law 96–265, the Social Security Disability Amendments of 1980. While the changes made in the benefit provisions were significant (such as the limitation on DI family benefits and the liberalization of Medicare for DI beneficiaries returning to work), the provisions having the greatest impact on the Social Security Administration were those that directly affected the operations of the program. The provisions required a dramatic increase in the amount of management review and oversight of the program. The major provisions in the Disability Amendments of 1980 intended to limit benefits and tighten administration are briefly described below.

A. Program Accountability Provisions

FEDERAL REVIEW OF STATE AGENCY DECISIONS

While the State agencies have always had the primary role in making findings of disability, the actual disposition of the case—the allowance or denial of benefits—has always resided with the Secretary of Health and Human Services. Thus, while the State agencies make the initial findings, the Federal Government—through its administering agency, the Social Security Administration—has to certify the decisions that are made.

Until the 1972–74 period, this oversight function was carried out by Federal disability examiners, located in what was then the Bureau of Disability Insurance of the Social Security Administration, who reviewed the findings of the State agencies. Although firm data is lacking, program officials believe that about 70 percent of State agency decisions were reviewed by Federal examiners. These reviews generally were conducted before the applicant or beneficiary was notified of the final disposition of his case; they were referred to as pre-adjudicative or pre-effectuation reviews.

Yielding to budget reduction initiatives, particularly tight manpower ceilings, the Social Security Administration moved rapidly away from this review function, beginning in 1972, toward a new review system under which only 5 percent of all State agency decisions would be reviewed, and then only after the claimant or beneficiary was notified of the State agency's determination (i.e., post-adjudicative review). Supposedly to back up this new "quality control" system, there would be enhanced quality control units in each of the State agencies.

The State agencies were confronted with heavy workload increases in the first half of the 1970s following the implementation of the Black Lung and SSI programs. Significant backlogs were accumulating at various stages of the claims process, and it was considered important to expedite the process. Many felt that the result was a decline in the quality of decisions which were being made.

One of the major criticisms made about the determination process was that uniformity of decisions was lacking and that different State agencies had been making decisions using different criteria. The report to the Senate by the Committee on Finance on the proposed amendments showed allowance rates for States agencies ranging from 22 percent in Alabama to 53 percent in New Jersey.

Furthermore, it was believed by many experts that numerous inaccurate decisions, particularly those allowing individuals into the program, were going undetected because the Federal review process only covered 5 percent of the cases. Later data showed that, for some period of time, even this 5-percent level was not achieved. The social security actuaries produced estimates showing that reinstitution of the old review process on allowances would reduce long-run costs by .05 percent of taxable payroll ($700 million per year in 1982 dollars).

Reacting to these concerns, both the House and Senate social security disability bills included provisions reinstituting the old process of pre-effectuation review. The new law called for pre-effectuation Federal review of at least 15 percent of allowances in fiscal year 1981, 35 percent in 1982, and 65 percent in years thereafter. The Finance Committee report elaborated on the provision by stating:

> The committee believes that while the Federal-State determination system generally works reasonably well (many State agencies do an excellent job), significant improvements in Federal management and control over State performance are necessary to ensure uniform treatment of all claimants and to improve the quality of decisionmaking under the Nation's largest Federal disability programs.
>
> The requirement of reviewing at least a fixed percentage overall does not mean that this same percentage would apply in every State, nor every stage of adjudication; the committee would expect that the Social Security Administration will review a relatively higher or lower percentage of determinations where this is merited. The requirement that this percentage of reviews be made prior to effectuation of the decision is not intended to preclude other reviews the Secretary may find appropriate either before or after effectuation nor actions he may take as a result of such other reviews.
>
> Although the language of the bill pertains only to the DI program, the committee expects that the review procedures implemented by SSA will be applied equally to both the DI and SSI programs, since the disability determination is, for the most part, the same for both programs.

However, the specific percentage goals would have to be met only for the title II program.

PERIODIC REVIEW OF DISABILITY DETERMINATIONS

Another area of concern regarding SSA's review functions was in the area of monitoring the continued eligibility of DI beneficiaries. Up until the 1980 amendments, there were no requirements for periodic redetermination of disability for all or even a sizable proportion of persons who were receiving disability benefits. The social security claims manual instructed the State agencies on certain kinds of cases that were to be selected for investigation by means of a medical diary procedure. The agencies were cautioned that most allowed cases involved chronic, static, or progressive impairments subject to little or no medical improvement. In others, the manual further stated that even though some improvement might be expected, "the likelihood of finding objective medical evidence of 'recovery' has been shown by case experience to be so remote as not to justify establishing a medical reexamination diary." In general, according to the claims manual, cases were to be "diaried" for medical reexamination only if the impairment was one of 13 specifically listed impairments.[1]

Many experts believed that this review process was not working effectively, permitting many recovered and incorrectly awarded beneficiaries to remain on the benefit rolls. The Finance Committee report stated:

> The high degree of selectivity used in designating cases for medical reexamination is illustrated by the following statistics for title II. In 1977, there were about 2.7 million disabled workers in current pay status. The number of continuing disability investigations (CDIs) in that year for disabled workers was only about 165,000. Numerous critics, including many within the Social Security Administration, believe that the highly selective diary criteria and other continuing review procedures are inadequate and result in the continued payment of benefits to many persons who have medically or otherwise recovered from their disability.

Responding to this concern, the Congress adopted a provision requiring that DI beneficiaries be re-examined at least once every three years, unless their conditions were expected to be permanent. The Finance Committee report elaborated on this provision in the following way:

> This review is not intended to supplant the existing reviews of eligibility that are already being conducted such as those under the current "diary" procedures. Moreover, the committee expects that even cases where the initial prognosis shows the probability that the condition will be permanent will be subject to periodic review, although not necessarily every three years in selective circumstances.

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[1] These diary criteria have been increased to 17 categories.

> The committee believes that such procedures should be applied on the same basis to the DI and SSI programs.

(Greater detail on the evolution of this provision is provided in Sections V and VI of this print.)

OWN MOTION REVIEW OF ALJ DECISIONS

In addition to the concern that had been building about the operations of the State disability agencies, there were many concerns raised in the late 1970s about the operation of the appellate stages, especially the hearing stage. The SSA administrative law judges (ALJ's) frequently were criticized not only for the variation in their productivity, but also for the variation in their reversal rates. It was pointed out that a person who requested a hearing could be assigned to what were referred to as either "easy" or "hanging" judges. In the period January–March 1979, 33 percent of ALJ's awarded claims to from zero to 46 percent of the disabled workers whose cases they decided, 46 percent of ALJ's awarded claims to from 46 to 65 percent, and 21 percent of ALJ's awarded claims to from 65 to 100 percent. Overall, the percentage of hearings that resulted in a reversal (an allowance of benefits) was increasing. In fiscal year 1969 the title II disability reversal rate was 39 percent. It increased to 46 percent in 1973, and by 1978 the reversal rate actually exceeded 50 percent. The SSI hearing reversal rate increased from 42 percent in fiscal year 1975 to 47 percent in 1978.

The report of the Finance Committee made the following statement on the situation:

> The committee is concerned about these State-to-State, ALJ-to-ALJ variations and about the high rate of reversal of denials which occurs at various stages of adjudication, for it indicates that possibly different standards and rules for disability determinations are being used at the different locations and stages of adjudication.

As pointed out in Section VII of this print, from 1975 to 1981, there were few procedures in place to provide a quality control check on the ALJ's. While a claimant or terminated beneficiary could make a further appeal of an ALJ denial to SSA's Appeal Council, there was no mechanism for the government (the Social Security Administration) to contest an ALJ allowance. Such a procedure, often referred to as "own-motion" review, had been in place prior to 1975, when inadequate resources were made available to both meet the heavy hearings workload brought on by the implementation of SSI and to continue a program of own motion review.

Originating as a floor amendment by Senator Bellmon, the provision in the 1980 amendments required that "own motion" review be reinstated, and that a report be given to Congress on the initial progress in reinstituting the procedures as well as the causes for the variances in ALJ decision-making.

OTHER ADMINISTRATIVE PROVISIONS AFFECTING THE DI PROGRAM

Although the new review procedures required by the 1980 amendments are probably creating the greatest impact on SSA and the DI program, numerous other administrative measures were in-

cluded in the 1980 amendments. A listing and brief description of the major ones follow:

ADMINISTRATION BY STATE AGENCIES

Prior law provided for disability determinations to be performed by State agencies under an agreement negotiated by the State and the Secretary of Health and Human Services. The relationship was contractual and State laws and practices were controlling with regard to many administrative aspects. State agencies made the determinations based on guidelines provided by the Department and the costs of making the determinations were paid from the disability trust fund in the case of DI claimants, or from general revenues in the case of SSI claimants. The agreements allowed both the State and the Secretary to terminate the agreement.

The 1980 amendments required that disability determinations be made by State agencies according to regulations or other written guidelines of the Secretary. It required the Secretary to issue regulations specifying, in such detail as he deemed appropriate, performance standards and administrative requirements and procedures to be followed in performing the disability determination function "in order to assure effective and uniform administration of the disability insurance program through the United States." Certain operational areas were cited as "examples" of what the regulations may specify. These include such items as the nature of the administrative structure, the physical location of and relationship among agency staff units, performance criteria and fiscal control procedures. The provision also provided that this shall not be "construed to authorize the Secretary to take any action except pursuant to law or to regulations pursuant to law."

The provision further provided that if the Secretary found that a State agency was substantially failing to make disability determinations consistent with regulations, the Secretary would, not earlier than 180 days following his findings, terminate State administration and make the determinations himself. The provision also allowed for termination by the State. The State would be required to continue to make disability determinations for not less than 180 days after notifying the Secretary of its intent to terminate. Thereafter, the Secretary would be required to make the determinations.

CLOSING THE RECORD—LIMIT ON PROSPECTIVE EFFECT OF APPLICATION

Prior law provided that if an applicant satisfied the requirements for benefits at any time before a final decision of the Secretary was made, the application was deemed to have been filed in the first month for which the requirements were met. One consequence of this provision was that the claimant was afforded a continuing opportunity to establish eligibility until all levels of administrative review had been exhausted, i.e., until there was a final decision. Thus, a claimant could continue to introduce new evidence at each step of the appeals process, even if it referred to the worsening of a condition or to a new condition that did not exist at the time of the initial application. This is frequently referred to as the "floating application" process.

The 1980 amendments provided for foreclosing the introduction of new evidence with respect to a previously filed application after the decision was made at the administrative law judge (ALJ) hearing. The amendments permitted a remand of the case to the ALJ level to remedy an insufficiently documented case or other defect at the Appeals Council level.

INFORMATION TO ACCOMPANY SECRETARY'S DECISION

Under the old law there was no statutory provision setting a specific amount of information required to be provided to explain the decision made on a claim for benefits.

The 1980 amendments required that notices of disability denial to DI and SSI claimants would use a statement of the case in understandable language and include: "A discussion of the evidence, and the Secretary's determination and the reason(s) upon which it is based."

PAYMENT FOR EXISTING MEDICAL EVIDENCE

Under the old law, authority did not exist for paying physicians and other potential sources of medical evidence for medical information already in existence when a claimant filed an application for DI benefits.

The 1980 amendments provided that any non-Federal hospital, clinic, laboratory, or other provider of medical services, or physician not in the employment of the Federal Government, which supplied medical evidence requested and required by the Secretary for making determinations of disability, would be entitled to payment from the Secretary for the reasonable cost of providing such evidence.

LIMITATION ON COURT REMAND

Under old law, prior to filing an answer in a court appeal of the final administrative decision, the Secretary of Health and Human Services could, on his own motion, remand the case back to an ALJ. Similarly, under prior law the court itself, on its own motion or on motion of the claimant, had discretionary authority "for good cause" to remand the case back to the ALJ.

The 1980 amendments limited the absolute authority of the Secretary to remand court cases. It required that such remands would be discretionary with the court upon a showing by the Secretary of good cause. A second provision related to remands by the court. The provision provided that a remand would be authorized only on a showing that there is new evidence which is material, and that there is good cause for having failed to incorporate it into the record in a prior proceeding.

B. DI Work Incentive and Related Measures

The major DI benefit provisions contained in the 1980 amendments were responses to concerns that part of the growth of the program was resulting from a lack of work incentives. Two provisions affecting the level of benefits, as well as changes in the Medicare program and modifications in the so-called "trial work

period", were enacted to make return to work more attractive to beneficiaries. A brief listing of these provisions follows:

LIMIT ON FAMILY DISABILITY INSURANCE BENEFITS

Under the old law, the combined benefit for the worker and all dependents was limited to no more than 150 to 188 percent of the worker's benefit.

The 1980 amendments limited total DI family benefits to the smaller of 85 percent of the worker's average indexed monthly earnings (AIME) or 150 percent of the worker's primary insurance amount (PIA). Under the provision, no family benefit would be reduced below 100 percent of the worker's primary benefit.

REDUCTION IN DROPOUT YEARS

Under the old law, disabled workers were allowed to exclude up to 5 years of low earnings in averaging their earnings. However, at least 2 years of earnings had to be used in the benefit computation.

The 1980 amendments called for the exclusion of low earnings in the computation of disability benefits according to the following schedule:

Worker's age at disablement:	*Number of dropout years*
Under 27	0
27 through 31	1
32 through 36	2
37 through 41	3
42 through 46	4
47 and over	5

The provision also allowed a disabled worker to drop out additional low years of earnings, if in those years there was a child (of such individual or his or her spouse) under age 3 living in the same household and the disabled worker did not engage in any employment in each such year. In no case would the number of such dropout years exceed 3. Further, dropout years for periods of childcare were provided only to the extent that the combined number of childcare dropout years and dropout years provided under the regular schedule did not exceed 3.

ELIMINATION OF SECOND MEDICARE WAITING PERIOD

Under the old law, DI beneficiaries had to wait 24 consecutive months after becoming entitled to benefits before becoming eligible for Medicare. If a beneficiary lost his eligibility and then became disabled again, another 24 consecutive month waiting period was required before Medicare coverage was resumed.

The 1980 amendments eliminated the requirement that a person who becomes disabled a second time must undergo another 24 consecutive month waiting period after becoming reentitled before Medicare coverage is available to him. The amendment applied to workers becoming disabled again within 60 months, and to disabled widows or widowers and adults disabled since childhood becoming disabled again within 84 months.

EXTENSION OF MEDICARE FOR AN ADDITIONAL 36 MONTHS

Under the old law, Medicare coverage ended when disability insurance benefits ceased.

The 1980 amendments extended Medicare coverage for an additional 36 months after cash benefits cease for a worker who engages in substantial gainful activity but has not medically recovered. (The first 12 months of the 36 month period is part of the new 24 month trial work period described below.)

EXTENSION OF THE TRIAL WORK PERIOD

In the DI and SSI programs under old law, when an individual completed a 9 month trial work period, and then in a subsequent month performed work constituting substantial gainful activity (SGA), his benefits were terminated. He obtained benefits for the first month in which he performed SGA (after the trial work period ended) and for the 2 months immediately following. Under the DI program, widows and widowers were not entitled to a trial work period.

The 1980 amendments, in effect, extended the trial work period to 24 months. In the last 12 months of the 24-month period the individual does not receive cash benefits while engaging in substantial work activity, but is automatically reinstated to active benefit status if earnings fall below the SGA level.

The provision also provided that the same trial work period would be applicable to disabled widows and widowers (who were not permitted a trial work period at all under old law).

TREATMENT OF EXTRAORDINARY WORK EXPENSES IN DETERMINING SGA

Regulations issued under prior law provided that in determining whether an individual was performing substantial gainful activity (SGA), extraordinary expenses incurred by the individual in connection with his employment and because of his impairment were to be deducted to the extent that such expenses exceeded what his expenses would have been if he were not impaired. Regulations specified that expenses for medication or equipment which the individual required to enable him to carry out his normal daily functions could not be considered work related, and could not be deducted even if they were also essential to the individual's employment.

The 1980 amendments provided for a deduction from earnings of costs to the individual of extraordinary impairment-related work expenses, attendant care costs, and the cost of medical devices, equipment, and drugs and services (necessary to control an impairment) for purposes of determining whether an individual is engaging in substantial gainful activity, regardless of whether these items are also needed to enable him to carry out his normal daily functions. The Secretary was given the authority to specify in regulations the type of care, services and items that may be deducted, and the amounts to be deducted would be subject to reasonable limits to be prescribed by the Secretary.

TERMINATION OF BENEFITS FOR PERSONS IN VOCATIONAL REHABILITATION PROGRAMS

Under the prior law, an individual was not entitled to DI and SSI benefits after he had medically recovered, regardless of whether he had completed the program of vocational rehabilitation in which he had been enrolled.

The 1980 amendments provided that DI benefits would continue after medical recovery for persons in approved vocational rehabilitation plans or programs, if the Commissioner of Social Security determined that continuing in those plans or programs would increase the probability of beneficiaries going off the rolls permanently.

WORK INCENTIVE AND OTHER DEMONSTRATION PROJECTS UNDER THE DISABILITY INSURANCE PROGRAM

Under the prior law, the Secretary of Health and Human Services had no authority to waive requirements under titles II, XVI, or XVIII of the Social Security Act to conduct experimental or demonstration projects.

The 1980 amendments authorized the waiver of benefit requirements to allow demonstration projects by the Social Security Administration to test ways in which to stimulate a return to work by disability beneficiaries. It also authorized waivers in the case of other DI demonstration projects which SSA wished to undertake, such as studies of the effects of lengthening the trial work period, altering the 24 month waiting period for Medicare benefits, altering the way the disability program is administered, earlier referral of beneficiaries for rehabilitation, and greater use of private contractors, employers and others to develop, perform or otherwise stimulate new forms of rehabilitation.

V. RECENT REPORTS ON THE ACCURACY OF THE BENEFIT ROLLS

When the 1980 amendments were enacted requiring the periodic review of the eligibility of DI beneficiaries, they were not based on specific evidence that a large number of ineligible recipients were on the rolls. Rather, they were based on concern over the rapid growth which had occurred in the program during a period when administrative actions to ensure accuracy had been sharply reduced. Little statistical data was available on the overall accuracy of the DI benefit rolls.

For years there had been sample-oriented systems within SSA designed to measure how well decision-makers at SSA and the State agencies were adhering to operating policies and procedures. These reviews, however, were largely "paper reviews" of the files and concentrated primarily on a limited number of cases moving through the process. The reviews did not involve random, periodic spot-checks on the entire benefit rolls. When called upon to produce national accuracy statistics, these systems rarely showed more than a two or three percent case-error rate, although it was generally recognized that these systems were not designed to provide a reliable overall accuracy rate.

In 1976 and 1977, due to concern about the lack of data on quality, SSA planned a major new system to measure the overall accuracy of the OASI and DI benefit rolls. The new "quality assurance" system was to parallel the systems of periodic cross-section sampling of the rolls that was in use for the SSI and AFDC programs. By 1979, the OASDI quality assurance system took shape as pilot studies were undertaken. Last year, data was released on the findings for the DI program.

The findings of the first pilot study were formally described in a General Accounting Office report issued early in 1981. The central finding of the report was that the data in the first SSA pilot study indicated that the overall payment inaccuracy rate in the DI program could be as high as 20 percent, with more than 90 percent of these cases involving people who were completely ineligible. The second pilot study suggested the payment inaccuracy rate could be as high as 30 percent.

A. The GAO Report, March 1981

In December 1980 GAO circulated a draft report suggesting that as many as 584,000 people, or about 20 percent of those on the DI benefit rolls, might not be disabled within the meaning of the law, but were still receiving benefits. Based on this report, SSA announced that as part of the President's fiscal year 1982 budget, the periodic review of the continuing eligibility of beneficiaries, mandated by the 1980 amendments, would begin immediately rather

than await the January 1982 date at which time the procedure became mandatory under the 1980 law. SSA thus accelerated the periodic review, beginning it in March 1981.

The formal GAO report, entitled "More Diligent Followup Needed to Weed Out Ineligible SSA Disability Beneficiaries," was released in March 1981. (See Appendix B for text of report.) It was based primarily on early findings of the SSA quality assurance pilot study which, according to GAO, was a "good indicator—probably the best one available—that ineligibility in the DI program is a costly problem that must be corrected." According to the report, as much as $2 billion annually in social security benefits might be going to 584,000 individuals who were no longer disabled. "Although it may not be realistic to expect that all ineligible beneficiaries could be removed from the rolls, substantial savings would be achieved if Social Security stepped up its investigative efforts."

The report described certain of the causal factors that SSA believed led to the high error rate. First, because of the heavy workload with the introduction of SSI in the early 1970s and limited quality assurance in the mid-1970s, people who simply did not meet the eligibility requirements were allowed onto the DI rolls. Also, because of inadequate administration of the review of continuing disability, many beneficiaries who should have been scheduled for reexamination (because of a disability that was expected to improve) were not, and many scheduled medical reexaminations were never done. Based on a 14 percent sample of 1975 DI awards, GAO found that 52 percent (15,746) of the cases scheduled for a medical reexamination under SSA's continuing disability investigation procedures were never performed. It was estimated that from 5,800 to 12,600 people awarded benefits in 1975 were not, in fact, disabled under the meaning of the law but were continuing to receive benefits. As stated in the report, "These problems exist because of a lack of effective internal controls over the process."

GAO pointed to other problems that went well beyond administrative inefficiency or lack of quality control. Most notably, the report stressed the fact that there were policies and practices being pursued in the early to mid 1970s that made individuals who no longer met DI eligibility criteria difficult to remove from the rolls. The State disability examiners and the social security administrative law judges—the individuals involved in making the decision as to the continued eligibility of DI beneficiaries at the stage of the initial determination and at the stage of appeal—had been operating under a policy which precluded disability examiners from terminating beneficiaries who were erroneously allowed onto the rolls in the first place. In effect, the termination decision had to be based on evidence of medical *improvement,* not simply evidence that the individual failed to meet eligibility requirements. According to GAO:

> SSA had a policy in effect from 1969 until 1976 called the LaBonte principle (named after an administrative law judge's hearing decision) which stated that terminations had to be based on documentation which supported medical improvement. Under this principle, all initial disability decisions were presumed to be correct—even though this

was not always true. As a result, when SSA discovered through medical reexamination that a person had been erroneously awarded DI benefits and was never disabled, the individual was allowed to remain on the rolls because there was no evidence of medical improvement.

Finally, of significance, was GAO's finding that "annual wage reporting" adversely affected SSA's ability to monitor the work activity of DI beneficiaries. Legislation enacted in the mid-1970s permitted employers to drop the procedure of reporting employee wages to the Government each calendar quarter. Instead, beginning with calendar year 1978, wage reports would only have to be filed annually. The lag time and procedural problems associated with annual wage reporting have made the performance of work-related continuing disability investigations much more difficult than they were prior to 1978.

B. Internal SSA Payment Accuracy Samples

To date, the new payment accuracy measurement system created by SSA, still in its early stages, has only produced data from pilot studies. (Data from the first ongoing review sample, covering the period October 1981 to March 1982, is currently being analyzed.) The pilot studies, such as the one used by GAO in preparing its March 1981 report, were intended primarily to work out the procedures under which an "ongoing" payment accuracy measurement system would operate.

DI Pilot Study—Phase I.—The first pilot study was conducted during 1979 and 1980 and consisted of a review of 3,154 cases randomly selected from all of the cases receiving benefits in April 1979. The findings from this study showed that, based on quality review procedures, over 20 percent of the cases reviewed either were ineligible or received a higher payment than they were entitled to. Of these cases, over 90 percent should not have been entitled to any benefits in that month. This translated into over $185 million in benefits in April 1979 (projected to the entire population) that should not have been paid. Annually, it projected to over $2 billion being misspent in monies from the DI trust fund.

Not only did the findings from the first pilot study indicate that a major problem existed in the DI program, but also the findings were key in setting up "profiles" of highly error-prone cases to be examined under the new periodic review process. The basic premise for using this technique for selecting cases for review is that targeting in-depth reviews to cases with the characteristics of a high error profile will result in a higher payoff than reviewing random groups of cases. SSA has had considerable experience with the use of the profiling technique to select and develop redetermination cases in the SSI program and found it to be effective in terms of increased accuracy and more efficient use of staff resources.

Using the results of the first DI payment accuracy study, 20 profile groups were identified with the average dollar error per case ranging from $26 to $311. Cases were selected for continuing disability investigation review in 1981 based on characteristics of the high error prone profile groups.

DI Pilot Study—Phase II.—The second of the DI pilot studies was conducted in 1980 and 1981 and involved the review of 2,817 cases randomly selected from all of the cases receiving benefits in July, August or September 1980.

Using the experience from Phase I, several changes in the study procedures were made for Phase II. These changes included:

(1) Full medical development, including one or more consultative examinations, was required in all but a few cases. This was to assure complete and adequate medical evidence.

(2) A second review of all cases was completed in the central office with priority given to medical discrepancy cases. These reviews were performed by a selected group of medical consultant staff physicians. Cases where medical disagreements were evident between the first and second reviews were subjected to a third panel review.

The findings from the second pilot study were consistent with the findings from the first study although the observed discrepancy rates were higher than those observed in the first study. Over 30 percent of the cases reviewed received a larger benefit than the reviewers determined should have been paid (compared to 20.3 percent in Phase I). Based on quality review findings, in over 85 percent of these excess payment cases, the beneficiaries should not have been entitled to any benefits. These findings equated to a projected $1 billion paid in error during the 3-month period July–September 1980.

Excess payments of a medical nature accounted for over 98 percent of all excess payments. Cases involving the musculoskeletal system, the cardiovascular system or mental disorders comprised over 72 percent of the medical discrepancies. Cases where the individual became entitled during 1974–1977 were more error prone than cases where entitlement began in subsequent years.

The Office of Assessment of SSA evaluated the circumstances surrounding the medical discrepancies and attributed over half of them to lack of meaningful contact with the beneficiary subsequent to the latest determination. That is, SSA failed to initiate or follow through on a continuing disability investigation, and the beneficiary failed to contact SSA to report improvements in his/her condition or return to work.

Even the non-medical errors, both for excess payments and underpayments, were greatly influenced by factors unique to the DI program. Deficiencies relating to the reporting of worker's compensation were responsible for over 18 percent of the non-medical excess payments and 19 percent of the underpayments. (There is a limit to the amount of DI benefits an individual can draw if he also receives worker's compensation benefits.) In total, however, non-medical discrepancies accounted for only 1.4 percent of the excess payments which projected to about $15 million misspent for the 3-month period being studied.

Information was also gathered on the level at which claims were allowed (initial determination at the State agency level, reconsideration, hearing before an administrative law judge, etc.). Over 73 percent of the sample cases were allowed at the initial level. Although 24 percent of these cases were determined to contain medical discrepancies, this was the lowest observed discrepancy rate of

the major levels of allowance. Cases allowed by administrative law judges had an observed case discrepancy rate of 57.3 percent.

Finally, underpayment information was also gathered. The study indicated that beneficiaries were underpaid a projected $13.6 million for the 3-month sample period. This is equivalent to 0.4 percent of spending on DI beneficiaries.

It should be pointed out that because these findings were obtained through a pilot study, there are limitations on the reliability of the data. The sample of cases selected was from all DI cases receiving payments in any of the 3 months, so the data may not reflect the results over a longer period of time. Also, the pilot study represented only the second time the forms and procedures for this new quality review process were used, and there were some modifications in the forms and procedures. In spite of these constraints, the data is considered useful management information for pointing out problem areas associated with the DI program and for planning corrective action.

VI. CONTINUING DISABILITY INVESTIGATIONS: DEVELOPMENT AND CURRENT STATUS

A. What Are Continuing Disability Investigations (CDI's)?

The administering agency for any Government entitlement program has an ongoing responsibility to assure that the people who receive benefits continue to meet eligibility requirements. Such is the nature of SSA's responsibility with regard to the continuing disability investigations (CDI's) conducted under the DI program. "CDI" simply refers to the periodic review of the medical condition and employability of people receiving disability benefits.

The conduct of continuing disability investigations is an integral part of the DI program, as much so as the process of taking initial claims. This is due to the nature of the social security disability program, which is quite unlike that of an automatic annuity or disability indemnity program. Social security is an earnings replacement program, with disability insurance benefits providing partial replacement of earnings to insured workers who are no longer able to engage in substantial gainful activity. Benefits are payable only so long as the impairment continues. Unlike certain other public or private disability programs, benefits are not paid automatically in the event of an injury or accident, nor are they payable permanently, absent continued impairment.

SSA monitors the eligibility of DI beneficiaries in three ways. One method is the "diary" approach. Typically, if an initial entrant into the program has a condition that is likely to improve, the disability examiner who makes the decision will schedule (or diary) a later re-examination, i.e., a CDI. Typically, this re-examination will occur at yearly intervals. Also included in this category are cases where voluntary reports of medical improvement are submitted by beneficiaries. The second method of monitoring is when an individual engages in a "trial work period" during which he is monitored to determine if he is able to sustain work activity sufficient to be considered "substantial gainful activity." Also in this category are "work activity" cases that the agency identifies from earnings reports from either the beneficiary or from employers. These basic categories of CDI's are the traditional methods of monitoring the DI rolls.

The third and newest method is the periodic review procedure mandated by the Disability Amendments of 1980. As previously described, this method calls for a review of the eligibility of each disabled worker beneficiary at least once every three years, unless his condition is believed to be of a permanent nature (in which case periodic reviews of eligibility are still mandated, but need not be as frequent).

In fiscal year 1982, SSA expects to conduct about 500,000 DI and SSI CDI's. Almost one-third of the costs of the State disability de-

termination services will be incurred to carry out these re-examinations. Funding for the State agencies has increased 64 percent from fiscal year 1980 to fiscal year 1982, with the number of staff-years of work performed by the State agencies having grown by more than 3,000 (from about 10,000 to well over 13,000 this year). (CDI procedures are described in more detail in sections VIII C and F.)

B. Historical Development

SSA has always had the responsibility to terminate disability benefits if evidence shows the beneficiary is not disabled within the meaning of the law. The original definition of disability in the 1956 Act required that in order to qualify for benefits, the worker had to be unable to "engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration." In its report on the 1956 Social Security Amendments, the Committee on Ways and Means of the House of Representatives stressed the conservative design of the disability program. The report stated "an individual who is able to engage in any substantial gainful activity will not be entitled to disability insurance benefits even though he is in fact severely disabled." During the House floor debate on the disability provisions in the 1956 amendments, Representative Wilbur Mills said "This means that we intend that the program be strictly and conservatively administered."

The Congress provided for a strict definition of disability because it was fearful of runaway costs. In this regard, the committee report emphasized the purpose of paying benefits only when the disabling condition exists. The report stated:

> The benefits would terminate with the month before the month in which the individual died or reached retirement age or his disability ceased.

The report went on to emphasize the role of the Secretary in monitoring continued eligibility with the following statement:

> The new section 225 of the act authorizes the Secretary to make current suspensions from benefits . . . when there is reason to believe that such individual's disability may have ceased to exist. The suspensions so made would be in the nature of temporary withholding until there is a determination whether the disability has ceased or until the Secretary believes the disability has not ceased . . . the Secretary shall promptly notify the State of the suspension and shall request a prompt determination of whether such individual's disability has ceased.

In 1965, when the "long-continued and indefinite duration" aspect of the definition was changed to the present 12 months' duration requirement, Congress once again indicated that it expected SSA to review the condition of beneficiaries periodically to assure prompt termination of benefits when a beneficiary ceased to be disabled. The report of the Ways and Means Committee stated:

> Your committee expects that, as now, procedures will be utilized to assure that the worker's condition will be reviewed periodically and reports of medical reexaminations obtained where appropriate so that benefits may be terminated promptly where the worker ceases to be disabled.

While SSA diligently adhered to the thrust of this language in the years immediately following the 1965 amendments, by the mid-1970s its monitoring activities had dropped off significantly. This is clearly revealed in the table below which shows the number of continuing disability investigations processed actually fell between 1970 and 1978, by about 50 percent, while the number of disabled-worker beneficiaries nearly doubled. The number of continuing disability investigations per 1000 beneficiaries thus fell from 111.8 in 1970 to a low of 29 in 1978. This occurred in spite of the fact that the program was liberalized in the mid-1960s (1965 and 1967 amendments) to allow younger and less-permanently disabled individuals onto the rolls.

TABLE 12.—COMPARISON OF CONTINUING DISABILITY INVESTIGATIONS (CDI'S) PROCESSED TO TOTAL DISABLED-WORKER BENEFICIARIES OVER THE YEARS

Fiscal year	CDI's processed (DI and concurrent cases only)	DI-worker beneficiaries (in millions)	Number of CDI's per 1,000 DI-worker beneficiaries
1970	[1] 167,000	1.493	111.8
1973	[1] 142,000	2.017	70.4
1974	[1] 120,000	2.237	53.6
1975	[1] 116,000	2.489	46.6
1976	[1] 129,000	2.670	48.3
1977	107,220	2.834	37.8
1978	83,651	2.880	29.0
1979	94,084	2.870	32.8
1980	94,550	2.861	33.0
1981	168,922	[2] 2.835	59.6
Oct. 1, 1981 to June 28, 1982	243,785	[2] 2.723	89.5

[1] Figures provided by SSA in 1977, but not currently verifiable.
[2] Estimates based on intermediate II–B assumptions in the 1982 Trustees' Report.

Source: SSA and Social Security Bulletin, Annual Statistical Supplement, 1980.

A number of factors have been pinpointed by analysts for having contributed to lax administration of the DI program in the early to mid-1970s. For instance, a severe economic downturn and rising unemployment may have prompted a larger than usual number of ambiguous claims. Under those conditions, time consuming cases would increase and the normal claims determination process may have become overloaded. Others have pointed to the strain placed on the administrative system by having SSA process black lung claims in the early 1970s and, shortly thereafter, having it take over the State disability welfare rolls upon implementation of the

SSI program. Under the conditions imposed by these heavy workloads, many claims may not have been well enough developed to assure that the individuals involved were, in fact, eligible for DI benefits. Further, the necessity of continuously monitoring DI took second place to concerns over the time it took to process initial claims. Adequate administrative resources to manage the initial claims caseload and properly monitor eligibility were not obtained for the agency.

SSA was criticized in 1976 by the Ways and Means Committee staff for not adequately managing the CDI process. In a report to the committee, the staff cited criticisms levied by the State agencies and by the General Accounting Office, and presented statistics showing that there was little change in the number of CDI terminations between 1973 and 1975. They noted the peculiar situation where more beneficiaries were terminated because of recovery in 1967, with only 1.5 million persons on the rolls, than in 1974, when there were 2.5 million persons on the rolls.

The following table shows the relatively static level of total DI terminations due to recovery during the 10-year period 1967 to 1976.

TABLE 13.—DISABLED WORKER RECOVERIES,[1] 1960–81

Calendar year	DI-Worker terminations due to recovery	Recovery terminations per 1,000 DI-worker beneficiaries
1960	3,124	7.9
1961	2,936	5.4
1962	9,555	14.0
1963	12,931	16.4
1964	16,487	19.0
1965	18,441	19.4
1966	23,111	21.9
1967	37,151	32.1
1968	37,723	30.0
1969	38,108	28.0
1970	40,802	27.9
1971	42,981	27.1
1972	39,393	22.5
1973	36,696	18.9
1974	[2]38,000	17.8
1975	[2]39,000	16.3
1976	[2]40,000	15.3
1977	60,000	21.6
1978	64,144	22.3

TABLE 13.—DISABLED WORKER RECOVERIES,[1] 1960–81—Continued

Calendar year	DI-Worker terminations due to recovery	Recovery terminations per 1,000 DI-worker beneficiaries
1979	72,325	25.0
1980	([3])	([3])
1981	([3])	([3])

[1] Recoveries are due to return to work and medical improvements.
[2] Estimates.
[3] Not yet available.

Source: Experience of Disabled Worker Benefits under OASDI, 1974–78, Actuarial Study No. 81, April 1980.

These circumstances raised concern in Congress that SSA may have been failing to place enough effort into assuring that people remained eligible for DI once they were awarded benefits. This subsequently led to the provision in the 1980 amendments, which, as mentioned earlier, required that unless a DI beneficiary has been diagnosed as permanently disabled, he has to be reexamined at least every 3 years. This change did *not* give SSA new administrative authority, but merely established a "minimum review" requirement. The Report to the Senate from the Committee on Finance emphasized this point:

> The State agency not only has the function of deciding who comes on the disability rolls, it must also make determinations as to whether individuals stay on the rolls.
>
> There is, however, no requirement for periodic redetermination of disability for all or even a sizable proportion of persons who are receiving disability benefits. In general, according to the claims manual, cases are to be "diaried" for medical reexamination only if the impairment is one of 13 specifically listed impairments.[10]
>
> Numerous critics, including many within the Social Security Administration, believe that the highly selective diary criteria and other continuing review procedures are inadequate and result in the continued payment of benefits to many persons who have medically or otherwise recovered from their disability.
>
> *Committee bill.*—The committee provision provides that there will be a review of the status of disabled beneficiaries whose disability has not been determined to be permanent at least once every three years. This review is not intended to supplant the existing reviews of eligibility that are already being conducted such as those under the current "diary" procedures. Moreover, the committee expects that even cases where the initial prognosis shows the probability that the condition will be permanent will be subject to periodic review, although not necessarily every three years in selective circumstances. The committee believes

[10] Note that there are now 17 diary categories.

that such procedures should be applied on the same basis to the DI and SSI programs.

Although the number of disabled-worker beneficiaries judged to have permanent disabilities has not yet been determined, this mandate will likely require SSA to review, between 1982 and 1984, the continuing eligibility of most of the 2.8 million disabled workers now on the benefit rolls.

C. Current CDI Activity and Concern

An internal SSA quality assurance study conducted in 1979 (discussed in Section V of this print) indicated that as many as 18 to 20 percent of the people on the benefit rolls did not meet the requirements for disability benefits. As a result, SSA decided to accelerate the required review of disabled-worker beneficiaries. Subsequent to SSA's decision, the General Accounting Office issued a report (also discussed in Section V) making SSA's finding public and estimating that ineligible disability beneficiaries were receiving about $2 billion annually in benefits. They recommended that SSA expedite efforts to reevaluate the status of people on the disability rolls.

SSA began the accelerated review in March 1981, reviewing about 30,000 additional DI cases per month beyond the then "normal" review workload. (The SSI disabled were not subjected to the new review effort, except for those who were simultaneously entitled to DI benefits. Their exclusion was due primarily to resource limitations.) Table 14 shows the change in the State agencies' DI review workload that has since occurred.

TABLE 14.—CONTINUING DISABILITY INVESTIGATION ACTIVITY AND STATE AGENCY WORKLOAD UNDER THE DI PROGRAM, FISCAL YEARS 1981–82 [1]

Fiscal year	Total DI cases	
	Sent to State agencies	Reviewed by State agencies [2]
1980	123,310	94,550
1st quarter 1981	34,911	29,763
2nd quarter 1981	33,887	28,029
3rd quarter 1981	99,330	41,813
4th quarter 1981	141,992	69,317
Total 1981	310,120	168,922
1st quarter 1982	82,133	86,026
2nd quarter 1982	149,824	87,669
Total, first-half 1982	231,957	173,695

[1] Includes DI and concurrent DI/SSI cases. Excludes purely SSI disability cases.

[2] These figures do not include CDI's where the State agency has not had to make a new medical determination of disability.

Source: SSA, July 1982.

As shown, the number of DI CDI's sent to State disability determination services for processing nearly tripled in the third quarter of fiscal year 1981 (April–June), and increased by another 43 percent in the fourth quarter. The total number of CDI's sent in fiscal year 1981 accounted for roughly 11 percent of the disabled-worker beneficiary population. In the 2nd quarter of fiscal year 1982 more CDI's were sent to the States to process than in all of fiscal year 1980. (The number of SSI cases sent to States has ranged from 18,000 to 29,000 per quarter since the first quarter of fiscal year 1981. The total number was 70,198 cases in fiscal year 1980 and 95,814 in fiscal year 1981.)

Responding to the increased workload, State agencies have stepped up their review. Three times as many continuing disability investigations in the DI program were processed in the second quarter of fiscal year 1982 as in the second quarter of fiscal year 1981. Between January and March of this year, State agencies completed 87,669 continuing disability investigations.

Early this year when the President's fiscal year 1983 budget was issued, information about SSA's CDI workplan for fiscal years 1982 and 1983 was reflected in Appropriation justifications. These plans showed the following increases in total CDI's for both the DI and SSI programs for fiscal years 1982 and 1983:

TABLE 15.—PLANNED CONTINUING DISABILITY INVESTIGATIONS (CDI) ACTIVITY REFLECTED IN PRESIDENT'S FISCAL YEAR 1983 BUDGET, DI AND SSI PROGRAMS COMBINED

Processed CDI's	Fiscal year—			
	1980	1981	1982	1983
Regularly scheduled CDI's			152,000	152,000
Additional CDI's			415,000	654,000
Total	159,600	257,100	567,000	806,000

Source: Fiscal year 1983 SSA justifications to appropriations committees, supplemented by data supplied by SSA.

Note: These figures include CDI's where the State agency does not have to make a new medical determination of disability. These include cases where, for instance, the individual returned to work, as determined by SSA's district office staff.

Since that time, the Committee staff has been informed that SSA has scaled back its CDI estimate for fiscal year 1982 from 567,000 to 506,000, and that it is currently re-examining its estimate for fiscal year 1983.

The new review efforts of the Administration are well within the bounds of existing law. Concern has nevertheless been raised by the terminations that are now taking place at the State agency level. Initially, according to SSA, about 50 percent of the cases reviewed were being terminated for failing to meet eligibility requirements. Currently, some 45 percent of the DI cases reviewed are being terminated. (See Tables 16–18.)

As shown in the tables, this rate of "cessation" or benefit termination—in the range of 45–50 percent—is comparable to the rate over the period fiscal year 1978–1980, prior to the implementation of the accelerated review. Further, a relatively high rate of cessation should be expected between 1982–84, as the first of the required 3-year reviews are undertaken. Not only will this be the first time that many DI beneficiaries have been reexamined, but also (as discussed in Section V B) SSA is using procedures to select candidates for review that are targeted toward those with the greatest probability of ineligibility.

TABLE 16.—CONTINUING DISABILITY INVESTIGATION (CDI) CONTINUANCES AND CESSATIONS BY STATE AGENCIES, DI AND SSI COMBINED, FISCAL YEARS 1977–82[1]

Fiscal year	Total number of CDI reviews	Continuances	Cessations	Continuance rate (in percent)	Cessation rate (in percent)
1977	150,305	92,529	57,776	62	38
1978	118,819	64,097	54,722	54	46
1979	134,462	72,353	62,109	54	46
1980	129,084	69,505	59,579	54	46
1981	208,934	110,134	98,800	53	47
10/1/81–5/28/82	266,725	145,321	121,404	54	47

[1] Reflect continuance and cessation rates only at the State agency level—not at the district office or at the hearing or appeal levels of adjudication. These figures differ from the previous table in that they exclude CDI's where no new medical determination of disability by the State agency was required. Other factofs have affected the individual's entitlement, such as his return to work.

Source: SSA, July 1982.

TABLE 17.—STATE AGENCY CONTINUING DISABILITY INVESTIGATION (CDI) CONTINUANCES AND CESSATIONS, DI, SSI AND CONCURRENT CASES, SEPARATELY[1]

Fiscal year	DI cases				SSI cases				Concurrent cases[2]			
	Continuances	Percent of total reviews	Cessations	Percent of total reviews	Continuances	Percent of total reviews	Cessations	Percent of total reviews	Continuances	Percent of total reviews	Cessations	Percent of total reviews
1977	51,270	62	31,287	38	26,784	62	16,301	38	14,475	59	10,188	41
1978	35,800	54	30,715	46	19,293	55	15,875	45	9,004	53	8,132	47
1979	38,386	52	35,474	48	23,485	58	16,893	42	10,482	52	9,742	48
1980	40,228	54	34,798	46	19,228	56	15,306	44	10,049	51	9,475	49
1981	73,539	52	66,742	48	22,168	55	17,844	45	14,427	50	14,214	50
Oct. 1, 1981 to May 28, 1982	119,974	55	97,820	45	12,403	54	10,537	46	12,944	50	13,047	50

[1] State agency medical determinations only. The figures exclude CDI's where new medical determination of disability by the State agency was not required.
[2] Concurrent cases are those in which the individual is entitled to both DI and SSI disability benefits.

Source: SSA, July 1982.

TABLE 18.—RECENT ALLOWANCE RATES FOR INITIAL CLAIMS AND CDI DECISIONS, STATE BY STATE, DI AND SSI COMBINED

[In percent]

Initial claims [1]		Initial CDI decisions [2]	
State	Allowance rate	State	Allowance rate
Rhode Island	41.5	South Dakota	79.6
South Dakota	41.3	Alaska	72.8
Vermont	41.2	New Hampshire	69.8
Nebraska	40.2	Hawaii	69.6
		Nebraska	69.3
Alaska	39.5	Minnesota	68.3
Delaware	38.9	Vermont	67.6
Wisconsin	38.6	Wyoming	67.6
District of Columbia	38.5	Washington	67.0
Minnesota	37.2	Delaware	66.1
Utah	36.6	Maryland	64.5
Arizona	36.5	North Dakota	63.5
Iowa	36.1	Utah	62.6
Hawaii	35.6	Iowa	62.6
Indiana	34.7	Colorado	62.2
Kansas	34.6	Montana	61.3
Maine	34.3	Arizona	60.8
Connecticut	33.9	Missouri	60.4
North Carolina	33.9	North Carolina	60.2
New Jersey	33.7	Mississippi	60.1
Missouri	33.0	Massachusetts	59.9
Ohio	32.8	Oregon	59.7
North Dakota	32.8	Virginia	59.4
Illinois	32.6	Connecticut	59.3
Montana	32.5	Kentucky	58.3
Pennsylvania	31.9	South Carolina	58.0
New Hampshire	31.6	Ohio	57.9
Colorado	31.6	Maine	57.8
Nevada	31.5	Nevada	57.7
Wyoming	31.1	District of Columbia	57.4
Virginia	31.0	Kansas	56.6
South Carolina	30.9	Alabama	56.2
Oregon	30.9	West Virginia	55.9
Washington	30.8	Rhode Island	55.7
Florida	30.7	Indiana	55.4
Texas	30.3	Pennsylvania	55.3
Tennessee	30.2	Tennessee	54.8
Idaho	29.6	Michigan	54.5

TABLE 18.—RECENT ALLOWANCE RATES FOR INITIAL CLAIMS AND CDI DECISIONS, STATE BY STATE, DI AND SSI COMBINED—Continued

[In percent]

Initial claims [1]		Initial CDI decisions [2]	
State	Allowance rate	State	Allowance rate
California	28.9	Florida	54.1
Oklahoma	28.7	Georgia	53.5
Kentucky	28.5	Illinois	52.4
Maryland	28.2	California	52.1
Massachusetts	28.0	Idaho	51.5
Michigan	27.8	Oklahoma	51.5
Alabama	27.6	Wisconsin	49.8
Mississippi	27.5	Texas	49.0
Georgia	25.7	New Jersey	48.7
New York	25.4	Arkansas	48.2
West Virginia	25.3	New York	47.5
Louisiana	25.2	Louisiana	46.8
New Mexico	25.1	New Mexico	38.8
Arkansas	24.3	Puerto Rico	29.0
Puerto Rico	19.3		

[1] For fiscal year 1981.
[2] For period 10/81 to 5/82. Does not take appellate actions into account and excludes non-medical determinations.

Source: SSA, July 1982.

Also of recent concern is the apparently high rate of reversal of termination decisions upon appeal. The proportion of terminated beneficiaries who have had their denials reversed on appeal to an administrative law judge (ALJ), and thereby have had benefits reinstated, was 61 percent during the months February to May 1982. (Of the 16,797 CDI cases disposed of by ALJ's, 10,250 were reversals.) Historical data is illustrative in this regard. As shown in the table below, in recent years, ALJ's have tended to reverse about 55 to 65 percent of State agency denials, including initial denials and denials at the CDI stage.

TABLE 19.—ADMINISTRATIVE LAW JUDGE REVERSAL RATES—DISABILITY INSURANCE INITIAL DENIALS AND TERMINATIONS, FISCAL YEARS 1979–82

Fiscal year	Percent of cases reversed	
	Initial denials	Terminations
1979	56.4	59.5
1980	59.4	63.8
1981	59.0	61.5
1st quarter 1982	57.3	65.4

Source: SSA, July 1982.

TABLE 20.—ALLOWANCE RATES FOR VARIOUS TYPES OF DI DETERMINATIONS, 1970–81

[In percent]

Calendar year	Initial claims			CDI's
	Initial determination	Reconsideration	ALJ hearings	Initial determinations [1]
1970	44	33	42	[2]
1974	40	34	47	[2]
1975	40	33	49	[2]
1976	39	29	46	[2]
1977	38	28	47	62
1978	42	19	51	54
1979	39	17	55	52
1980	33	15	58	54
1981	29	12	57	52

[1] Fiscal year data. Includes only determinations made by State agencies involving medical reexaminations.
[2] Not available.

Source: Bellmon Report, and SSA, July, 1982.

The fact that, say, 45 percent of cases reviewed by State agencies are terminated and that ALJ's then reverse at a rate of 55 to 65 percent must be interpreted with caution. This reversal rate, of course, only pertains to cases that have requested a reconsideration, have had their denial upheld, and then have requested a hearing. For example, almost 70 percent of DI claims denied at the State agency level do *not* go on to request a hearing. As a result, ALJ's actually reverse one in six of the cases initially denied by State agencies.

Importantly, the concerns raised by the current CDI situation reflect long-standing issues in the administration of the DI program. They are issues that raise questions about the entire process in which disability determinations are made. Frequently, the concerns stem from over-expectations about the nature of determining disability—that it is or should be a completely objective process with cut and dried decisions. The decisions often involve complex medical questions about evaluation and diagnostic techniques about which even the medical community itself cannot reach a consensus. Moreover, the magnitude of the workloads—for both the initial

claims and continuing disability investigations—are staggering when one considers that individualized determinations make up a large portion of the decisions rendered. A high degree of uniformity may not be achievable.

However, a major issue that the CDI situation raises is the apparent lack of uniformity in the basic standard of disability from one stage of adjudication to the next—particularly between the determinations rendered by the State agencies and those by ALJ's at the hearing level. The fact that the ALJ's are reversing a high number of the State agency CDI decisions does not necessarily (nor does it likely) reflect inaccuracies in the decisions rendered at the State agency level. As pointed out in a later section, the situation may be one in which both the ALJ's and the State agencies are making basically correct decisions based upon the evidence available to them. The ALJ may be reviewing the case after the individual's condition has significantly deteriorated (i.e. since the State agency saw the case), and/or he may be basing the decision on new or additional evidence that became available after the State agency reached its decision. It must be noted, however, that under the new "own motion review" procedures, under which a number of ALJ decisions are being reviewed by SSA's Appeals Council, a significant number of ALJ decisions are being questioned. Furthermore, the discrepancies between State agency and ALJ decisions may arise from differing views of the meaning of the definition of disability in the law, as it pertains to individual cases, and how these two entities develop and weigh the evidence. The findings of the recent "Bellmon Report", discussed in the next section, tend to support the conclusion that "disability", for the purposes of the social security program, is a significantly different concept when applied at the State agency level than when applied in the appeals process.

The current situation also raises questions about the role of SSA and the Federal Government vis-a-vis the State agencies. Is there sufficient concern for the operational ramifications of major new policy initiatives? Is there enough appreciation for the limitations of the State agencies? Does SSA have an adequate system for assessing the quality of decisions rendered and also for effectively helping State agencies to improve their capabilities? In short, does the linkage between SSA and the State agencies have adequate administrative controls to assure that the disability determination process is being conducted with the greatest feasible degree of accuracy and uniformity?

More germane to the CDI situation, however, is the question of whether the actual results of the new periodic review process mandated by Congress were anticipated. Little attention was given in the 1980 amendments as to what the concept of "permanently impaired" was to mean in assessing whether or not an individual would be subject to the 3-year review cycle. (However, the legislative history clearly indicates that even "permanent" disabilities, however defined, were to be reexamined occasionally.)

Also, the 1980 amendments did not provide a distinction for the treatment of cases in which enrollment in the DI program began well before the enactment of the amendments, and in which no prior review of continuing eligibility had ever been conducted. Many of the current CDI cases fall into this category, involving

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older workers on the rolls for many years, who have never been reexamined. The extent to which such individuals would be found ineligible could not have been accurately predicted in 1980.

Another key issue is the appropriateness of current law and practice concerning the termination of benefits when the agency is unable to show that the disabling condition has improved, but nevertheless finds the individual ineligible for disability benefits. This involves the question of whether the agency (and therefore the DI trust fund), because it made borderline or erroneous decisions in the past, should be required to continue to support the individual. In particular, should an individual be terminated only if his situation has changed relative to the standard of disability or "adjudicative climate" existing when he first joined the benefit rolls, or should he also be terminated if the standard of disability or "adjudicative climate" has changed relative to his condition. Under current law and procedure, the latter is the case. Any individual who applies for disability benefits or who is reviewed for continuing eligibility is judged by the standards—the laws, regulations, rulings, and state of medical art—in effect at the time of determination. The State agency need not show evidence of medical improvement in order to find the individual ineligible for DI benefits.

There are several practical motivations for this practice. First, only by applying current standards and procedures can identically situated people (i.e., people with identical disabilities) be treated comparably as between those who are already on the rolls and those who are newly disabled and applying for benefits. Second, a medical improvement standard could, as it is said to have done prior to 1976, prevent the termination of benefits for cases that never met the eligibility requirements (see Section V A above). Finally, administratively, it is considerably more difficult to show *improvement* than to show failure to meet stated eligibility criteria. As discussed in Section IX C below, medical criteria are changed only infrequently to reflect advances in medicine, technology, and diagnostic techniques. Reversion to a prior standard would, in some cases, merely mean ignoring the current state of medical science.

Other questions raised about the CDI process involve: (1) The adequacy of SSA's evidence development procedures, particularly in the solicitation of evidence from treating physicians and vocational advice in cases where vocational factors need to be taken into account; (2) the amount of advance notice received by beneficiaries both prior to review and prior to termination; and (3) the length of time prior to appeal, during which benefits are not payable. Finally, there are practical concerns about whether or not the State agencies can handle the increased workload and whether or not SSA is headed for another "appeals crisis" that could dwarf the one that arose after the implementation of the SSI program. Will the agency be able to handle the enormous hearings and appeals workloads anticipated in the next few years as beneficiaries are terminated by the State agencies?

D. Recent GAO Findings

In recent testimony before the Subcommittee on Oversight on Government Management of the Committee on Governmental Af-

fairs, the General Accounting Office presented their findings from an ongoing study of the CDI process. According to the testimony, GAO began to review SSA's policies and practices for conducting continuing disability investigations in January 1982 because of concerns expressed over the medical condition of the beneficiaries being terminated. GAO representatives met with ALJ's and State officials and examiners in 4 States (California, New York, Pennsylvania, and Ohio) and examined 98 cases folders. Forty-two of the 98 cases reviewed, or about 43 percent, had resulted in cessations. Because of the small size of the sample, and the timing of the selection, GAO has not projected the results of the sample to the overall CDI process. Though preliminary, the findings are nevertheless illustrative.

The table below presents basic statistical information about the cases reviewed.

TABLE 21.—BASIC DATA ON CASES REVIEWED BY GAO

	Total	Cessations	Continuances
Number of cases	98	42	56
Average age of beneficiary	44	43	45
Average years on disability	8	7	9
Average case processing time [1] (in days)	102	127	83
Percent of cases where claimants' physicians contacted	71	69	74
Percent of contacts responding to DDS	85	90	81
Percent of cases with consultative exam ordered	67	86	54

[1] Counted from the date the beneficiary was first contacted concerning the review (either by mail or phone) to the date the DDS physician signed the notice of decision. This includes the 10 or more days allowed a beneficiary after being notified of the decision to submit any additional evidence.

GAO's findings from this preliminary study are briefly summarized below:

1. Processing time.—The amount of time required to process a CDI—from the date the individual is first contacted about a review to the date the determination of continuing eligibility is made—varied considerably. The shortest processing time found for a terminated case was 34 days, the longest was 368. GAO found no instances where beneficiaries were terminated without being given time to develop and present their medical evidence.

2. Medical evidence development.—Attending physician data is usually requested unless it is not relevant to the impairment, too old, or from a source known to be uncooperative. Only a few instances were found where examiners did not request evidence from what was felt to be a relevant source. While most sources did respond, there was significant variation in quality, quantity, and objectivity in their responses. Some portion of attending physicians' reports were not fully considered; however, GAO could not determine the extent of this or what impact this had on the final decision.

One aspect of State agency medical development highlighted by GAO is the practice of developing CDI cases as if they were new claims. GAO found that SSA has issued no specific development guidance for these cases, but rather has instructed the State agencies to adjudicate these claims in generally the same manner as initial claims. As a result, State agencies are gathering only current evidence—generally no more than 2 or 3 months old—and using this evidence to determine if the beneficiary currently meets SSA's criteria for disability. According to GAO, this practice can result in incomplete information and is one of the major reasons treating sources are not contacted or their information is not considered in the decision. It also helps explain the presence of a high consultative examination purchase rate.

3. Consultative exams.—The consultative examination purchase rate for continuing disability investigations cases in 1981 varied considerably (62 percent in Pennsylvania, 50 percent in Ohio, 58 percent in California, and 39 percent in New York). According to State examiners, these cases generally require consultative examinations more often than other claims because many people receiving disability benefits for a long period have not been to physicians recently. GAO did not attempt to evaluate the appropriateness of the consultative exam purchase rate or the quality of the exams purchased.

4. Evaluation of medical evidence.—In the late 1970s SSA made significant changes in the criteria and guidance used in the disability determination process. After considerable prompting by GAO and others, the vocational grid became a part of regulations in 1978, and in 1979, SSA revised the medical listings. The criteria became more explicit.

The changes in the medical listings have affected some beneficiaries who previously qualified under the old listings, but do not meet the criteria of the revised listings. In one case, for example, an individual was awarded disability benefits in 1975 following a heart attack. At that time, the medical listings only required evidence showing that the heart attack occurred, and that the claimant had chest discomfort. The revised medical listings for heart impairments now require specific exercise test results or specific readings from a resting electrocardiogram (EKG). While the beneficiary's resting EKG readings in both 1974 and 1982 show similar abnormalities and he continues to suffer from angina (chest pain), his benefits were terminated because the EKG readings do not meet the requirements of the new listings.

Similarly, beneficiaries put on disability because their condition "equaled" the listings are now being terminated because of a more narrow application of this concept.

The formalized vocational grid is also a factor in terminations. In the mid-1970s, many individuals whose impairments did not meet or equal the listings were allowed benefits because of vocational factors (age, education, prior work experience), even though there was little or no guidance available at that time on how to evaluate those factors. When reevaluating such beneficiaries, State agencies now terminate benefits in many of these cases because of the vocational grid. (For example, beneficiaries under age 50 with severe impairments that do not meet or equal the listings cannot be found

to be disabled unless they are illiterate or unable to communicate in English.)

In summary, GAO found some instances of poor development of medical records as well as some determinations that were not adequately supported. (GAO also questioned the State agencies' usual practice of gathering and evaluating only evidence that was from the most recent 3 months). According to GAO, however, the medical development issues are not unique to the CDI effort and are not the primary cause of the high number of cases being terminated. GAO testified that the way medical evidence is evaluated is a more significant factor in explaining the number of CDI terminations. GAO testified that:

> "* * * SSA is reviewing a group of beneficiaries who were awarded benefits several years ago under a more liberal, less objective evaluation process. These are generally people who were led to believe that they were being granted a lifetime disability pension. Now, with no advanced explanation from SSA about the purpose, process, or possible outcome of the Periodic Review—they are subjected to a new decision, much the same as if they were applying for disability benefits for the first time * * *
>
> "By getting a new decision, these beneficiaries have several disadvantages. The decision is made using a newer, more objective, more stringently interpreted set of evaluation guidelines; and is made in a tougher 'adjudicative climate.' At the same time, these decisions are subject to the same inherent weaknesses that have always plagued the SSA disability determination process—subjectivity, and medical development of questionable quality and completeness."

In a letter to the Secretary of HHS, dated July 14, 1982, GAO recommended that the Secretary require the Commissioner of Social Security to take the following actions:

> 1. Notify all disability beneficiaries and explain to them the purpose of the periodic review, and the importance of their providing complete and current medical evidence. If these reviews are to remain "new determinations" with little consideration given to the prior determination, this aspect should be fully explained to the beneficiaries.
>
> 2. Issue policy guidance to the State agencies emphasizing the uniqueness of the periodic review cases and the need for a full medical history in all cases. Specifically, SSA should establish a policy that can be uniformly applied by State agencies to ensure that a complete medical history is obtained and evaluated in all cases before benefits can be terminated for medical reasons. The medical history should cover the period from the initial disability determination and include medical information used in the initial determination.
>
> 3. Establish a processing time goal for managing the periodic review caseload that is commensurate with thorough development of medical evidence.

Workload

Recently, the GAO made data available to the Committee which sheds light on another concern—the ability of State agencies to

handle the increase in the CDI workload during 1981. As shown below, the monthly case workload for all types of disability cases (DI and SSI initial claims and continuing disability investigations) increased by six-tenths of one percent between 1980 and 1981, while the number of full-time case examiners increased by more than 29 percent. The relatively small increase in workload resulted from a shift in composition—there were fewer initial claims and more CDI's to process in 1981. Workload will increase more substantially as the CDI process is stepped up in 1982 and 1983.

TABLE 22.—DISABILITY DETERMINATION SERVICE WORKLOAD COMPARISON, DISABILITY CASES RECEIVED: 1980–81

	1980	1981	Percent change
Total workload [1] (monthly average)	247,512	249,006	+0.6
Full-time examiners (as of Dec. 31)	3,130	4,057	+29.6

[1] Includes DI and SSI initial claims and continuing disability investigations.

Source: State Agency Operation Report (SAOR).

VII. GENERAL DISABILITY DETERMINATION ISSUES—BELLMON REPORT FINDINGS

As suggested in the previous section, a number of the concerns about the periodic eligibility reviews mandated in the 1980 amendments reflect long-standing issues in the administration of the DI program. One of the more significant of these is the lack of uniformity among the different levels of adjudication—the State agencies, the administrative law judges (ALJ's) and the Federal courts. As illustrated in table 23 below, State agencies, on reconsideration, are allowing cases at a rate of 13 percent—affirming the initial disability determination in 87 percent of the cases; ALJ's are reversing 58 percent of the cases appealed. In 1 out of the 6 cases in which benefits are denied or terminated at the initial State agency level, the decision is reversed (and benefits are granted) at the ALJ level. An even higher percentage of CDI terminations are being reversed at the ALJ level.

TABLE 23.—RECENT DI ALLOWANCE RATES, INITIAL CLAIMS AND CDI'S SEPARATELY

Level of adjudication	Percent of cases allowed	
	Initial claims [1]	CDI's [2]
Initial	30	55
Reconsideration	13	12
Hearing	58	61

[1] Fiscal year 1981.

[2] October 1981 to July 1982 for initial and reconsideration decisions; February 1982 to May 1982 for hearings.

Source: SSA, July 1982.

An understanding of this phenomenon is essential for evaluating the continuing disability investigation review process—its problems and prospects. Frequently, ALJ reversal rates are misunderstood in that they are seen as indications of the degree of error at the State agency level. In fact, however, the reversal rate at the ALJ level may be the consequence of new or additional evidence submitted after the State agencies have made their decisions. Reversals are also the consequence of a worsening of the claimant's condition between the State agency and ALJ decisions. Furthermore, recently released data on the new "own motion" review of ALJ decisions indicates that defects are appearing in 43 percent of the decisions reviewed, with 17 to 18 percent of the cases involving deficiencies so significant that they are being reversed by SSA's Appeal Council or remanded back to the ALJ for reexamination.

The "Bellmon Report," required by the Disability Amendments of 1980 (Sec. 304(g)), constitutes the first comprehensive study of ALJ decisions. It provides important data and information on whether ALJ decisions are in line with the law, regulations, and other policies they are supposed to adhere to. It also is the first attempt to lay out how the decisions reached by the ALJ's are made, and why they often diverge so significantly from decisions made at other stages in the disability determination process. The legislatively mandated report was prompted by a lack of agency review of ALJ allowances.

A. Background

Under Federal regulations, the Appeals Council in SSA's Office of Hearings and Appeals has always had the authority "on its own motion or on request for review", to review ALJ hearing decisions. Traditionally, this was a major function of the Appeals Council. In 1975, however, because of the pressure of a mounting caseload within what was at that time the Bureau of Hearings and Appeals, the 'own motion' review process was for the most part abandoned.

In the next 5 years, there was effectively no Federal review of ALJ allowances (reversal decisions). Over the same period, the number of cases appealed to ALJ's and the proportion of those cases that were reversed rose appreciably. (See Tables 20 and 24.) Concern over the quality—the accuracy and the consistency—of the increasing number of ALJ decisions led the Senate to adopt the Bellmon Amendment, which was incorporated in the 1980 disability amendments.

As enacted, the provision requires SSA to institute a program of ongoing review of ALJ decisions.[11] Decisions which do not meet the criteria of having conformed to statute, regulation, and binding policy are to be administratively reversed. The provision also required the Secretary of Health and Human Services to submit to the Congress by January 1982 a report on progress toward implementing the ongoing review.

The conference report on the disability legislation specified that information in the Secretary's report should identify and help to quantify the factors leading to the high reversal rate by ALJ's of disability determinations. In particular, information was sought on the effects of five specific factors on ALJ decisions:

- Claimants' first appearance in person before a decision-maker;
- Additional evidence submitted at the hearing level;
- Significant changes in State agency denial rates;
- Differences between State agency (DDS) and ALJ policy guidelines; and
- Differences in standards applied by ALJ's.

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[11] SSA began an own motion review program on Oct. 1, 1981, under which 7½ percent of all social security and concurrent social security-SSI disability allowances made by ALJs were reviewed; in April 1982, SSA increased its review to 15 percent of those decisions.

B. Findings of the Bellmon Report[12]

Responding to this Congressional mandate, SSA conducted a study in which two groups reviewed 3,600 disability decisions made by ALJ's: the Office of Assessment within SSA, using the standards and procedures governing the State disability agencies (DDS's), and the Appeals Council, using the standards and procedures governing ALJ decisions. The major finding, according to the report, was that "significant differences in decision results were produced when different decision-makers were presented with the same evidence on the same case." While the ALJ's originally allowed 64 percent of the sample cases, the Office of Assessment allowed only 13 percent and the Appeals Council allowed 48 percent. The study found that a primary reason for the variation in allowance rates was the difference in decision-making criteria used at various stages of the determination process—even with regard to fundamental interpretations of what the law means.

In adjudicating disability claims, the State agencies are required to use a detailed set of administrative instructions known as the POMS (Program Operating Manual System). These instructions amplify and interpret the social security law and regulations and the social security rulings. The POMS contain specific standards and procedures with which the State agency must comply in making disability determinations; they are intended to ensure uniformity of State agency and SSA operations.

The ALJ's, by contrast, are not bound by the POMS and do not use them in making disability decisions. Instead, ALJ's rely on their own interpretations of the social security law and regulations, the social security rulings and the Office of Hearings and Appeals Handbook to adjudicate disability claims.

Key areas were identified where standards and procedures differed between State agencies and ALJ's. According to the report:

> In certain instances, as for example the definition of "impairment not severe," the actual definition contained in the standards governing the ALJ's and the DDS's is not precisely the same. In other instances, ALJ practices result in findings that are not possible under the DDS standards. Finally, in some areas the definitions contained in the standards may be the same—the Medical Listings are the primary case in point—but the procedures actually used for evaluating evidence to determine whether or not an individual's impairment meets the definitions are often quite different.

The findings of the Bellmon study tend to substantiate the contention that part of the reason for reversals at higher levels of appeal is that the cases are changing in nature and development. In effect, "floating applications" are moving through the stages of appeal. Reversals thereby lose meaning as an indicator of the correctness of lower level decisions. The study shows, for example, that additional medical evidence, submitted after the stage of the

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[12] The full text of the report is reprinted in Appendix B.

State agency reconsideration decision, significantly affects ALJ allowance rates. The ALJ allowance rate dropped from 46 percent to 31 percent when all evidence added after the reconsideration decision was deleted. Of the sample cases with additional medical evidence (74 percent), in almost all cases the evidence pertained to a previously alleged medical condition rather than to a new medical condition. Such additional evidence concerning prior conditions may have shown a change in the prior condition since the time of the earlier decision or provided more extensive documentation of the condition as it existed at the reconsideration level.

Concerning the evaluation of medical evidence, the report reveals that the physician involved in the State disability determinations and the ALJ involved in the appeal evaluate medical evidence in a qualitatively different way. The State DDS physician must make an independent judgment of the evidence provided as to whether the findings indicate the claimant is or is not severely impaired. ALJ's, on the other hand, do not tend to make independent evaluations of medical evidence, but rely more heavily on the conclusions reached by the treating physician or consulting physician that a claimant is "disabled" or "unable to work."

The findings of the Bellmon Report also suggest that the in-person appearance of claimants and terminated beneficiaries at ALJ hearings may contribute to the high reversal rate. The ALJ hearing is the first time that the claimant appears before a decision-maker. As part of the study, all information related to the appellant's face-to-face contact was removed from a sample of case folders and these folders were then distributed to other ALJ's for readjudication based on the case record. The original ALJ allowance rate of more than 60 percent dropped to 46 percent when the in-person information was removed from the case.

That in-person appearances make a difference in ALJ decisions should not be surprising. On a number of occasions, SSA has experimented with in-person appearance at the reconsideration level. While the results of these studies vary, they generally show that the allowance rate increases when the decision process includes a face-to-face appearance by the claimant. There could be a variety of reasons for this effect. For one, the decision-maker can see firsthand the claimant's appearance and functional limitations. A more subjective emotional effect—sympathy for an individual who appears to be severely impaired—may also be present.

Still another factor which may be of importance at the ALJ hearing stage is the representation of some claimants by lawyers or other advocates. In fiscal year 1981, 71 percent of claimants were represented at the ALJ hearing. In those cases where representatives were present, the ALJ allowance rate was 61 percent, as compared to an allowance rate of 48 percent when representatives were absent. A higher rate of allowance on the part of ALJ's may, in part, simply reflect the higher level of representation at that stage of the appeals process and the consequently greater development of cases. (To some extent, the higher rate of allowance for claimants represented by lawyers may reflect some degree of selectivity on the part of the lawyers in accepting claims which are more likely to be successful.)

On the whole, the Bellmon Report presents strong evidence that there is a significant lack of uniformity in the disability determination process—both between stages of decision-making and between ALJ's. The fact that large numbers of beneficiaries terminated under the CDI review process are having their decisions reversed on appeal may simply be further evidence to this effect—rather than an indictment of State agency decisions.

C. Other Problems in the Hearings Process

Other problems in the hearings process that have been noted over the years (and that may become matters of more significant concern under the ongoing review of continuing eligibility) are the slowness of decision-making at the ALJ stage and the inconsistencies that arise among ALJ decisions.

As illustrated in Tables 24 and 25, the hearings workload has increased considerably since 1970. In that year, there were only 14,000 requests for ALJ hearings. Black Lung cases, as well as the growing number of social security DI cases, swelled this to 104,000 requests by 1972. There were 282,000 requests in 1981. OHA estimates that the number of requests for ALJ hearings will rise to 326,300 and 415,700 in fiscal years 1982 and 1983, respectively. Part of this projected increase will be due to the implementation of the periodic review mandated in the 1980 disability amendments. Charts 5 and 6 illustrate the steady increase in the number of appeals requested and processed per ALJ.

The number of cases pending at the end of the year has generally remained relatively constant, at least until fiscal year 1975, as shown in Chart 7. Recent data indicate that the backlog of cases may be resuming its upward climb, reflecting the upsurge in the number of hearing requests. The result is that the number of cases pending per ALJ has reached an all time high—188 cases at the end of fiscal year 1981. The average time requiring until the ALJ decision is reached—after the hearing is requested—is 165 days.

TABLE 24.—REQUESTS FOR ALJ HEARINGS—RECEIVED, PROCESSED, AND PENDING TOTAL CASES[1]

Fiscal years	Requests received	Processed	Pending (end of year)
1960	13,778	20,262	5,959
1965	23,323	23,393	6,454
1966	22,634	23,434	5,654
1967	20,742	20,081	6,315
1968	26,946	25,939	7,322
1969	34,244	31,912	9,654
1970	42,573	38,480	13,747
1972	103,691	61,030	63,534
1974	121,504	80,783	77,233
1975	154,962	121,026	111,169
1976 (15 mo)	203,106	229,359	84,916
1977	193,657	186,822	91,751
1978	196,428	215,445	74,747

TABLE 24.—REQUESTS FOR ALJ HEARINGS—RECEIVED, PROCESSED, AND PENDING TOTAL CASES—Continued

Fiscal years	Requests received	Processed	Pending (end of year)
1979	226,200	210,775	90,212
1980	252,000	232,590	109,636
1981	281,700	262,609	128,164
1982	[2] 326,300	300,000	[2] 155,064

[1] Includes DI, OASI, SSI, and Black Lung cases.
Source: Estimate provided by SSA, OHA, July 1982.

TABLE 25.—HEARINGS AND APPEALS STATISTICS, FISCAL YEARS 1973–81

Fiscal year	Average number of ALJ's on duty [1]	Average support staff ratio [2]	Average hearings received per ALJ	Average dispositions per ALJ [1]	Average number of cases pending per ALJ [1]
1973	420	2.2	172	163	117
1974	478	2.7	254	169	122
1975	591	2.9	262	205	173
1976	647	3.6	244	277	153
1977	629	3.8	308	297	136
1978	657	3.9	299	328	128
1979	655	4.3	345	322	141
1980	669	4.4	377	333	169
1981	699	4.4	403	376	188

[1] Beginning in fiscal year 1978 includes regional chief ALJ's. Beginning March 1981 includes ALJs on detail from ICC. ALJ average dispositions are calculated to include the 9-month learning curve for new ALJs.
[2] Permanent staff fiscal year 1973–78; beginning fiscal year 1979 includes ALJ temporary positions.

Source: SSA, Office of Hearings and Appeals. 1982.

CHART 5

DISABILITY INSURANCE PROGRAM

HEARINGS REQUESTS PER ALJ

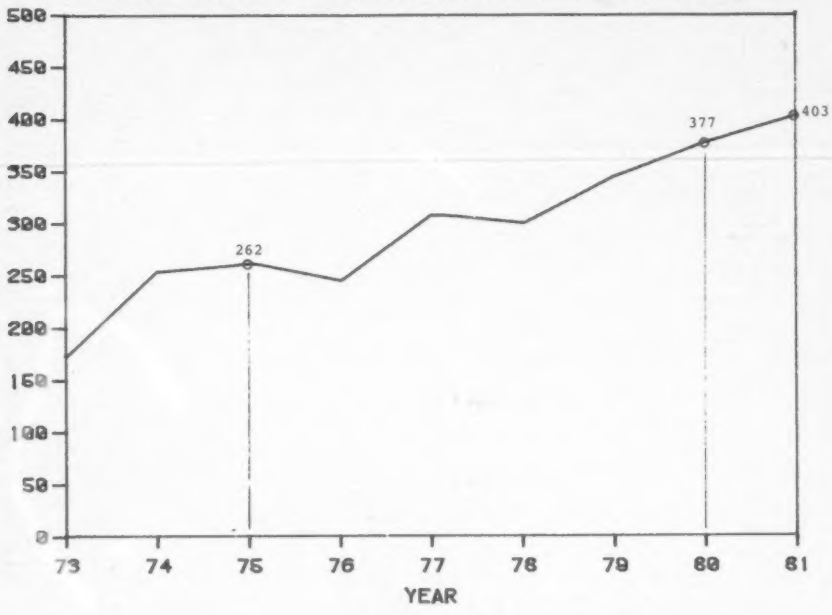


CHART 6

DISABILITY INSURANCE PROGRAM

HEARING DISPOSITIONS PER ALJ

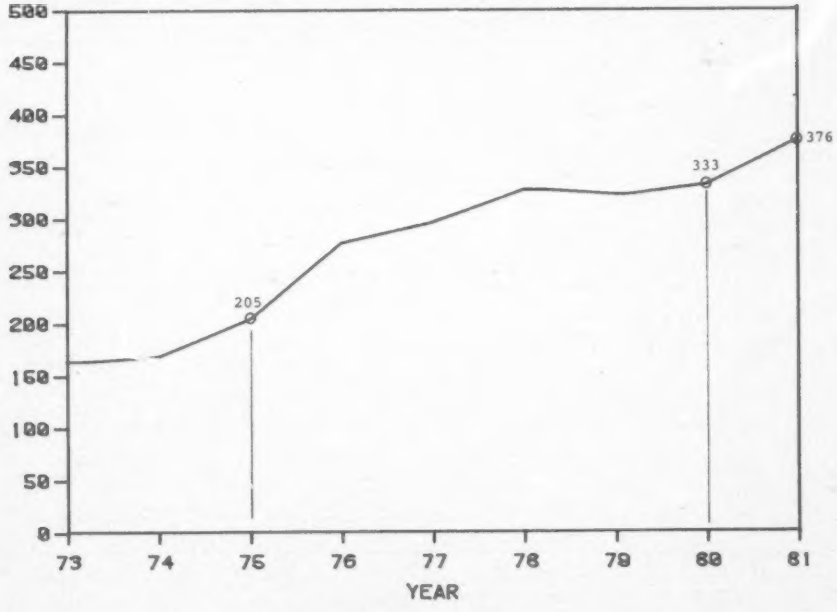
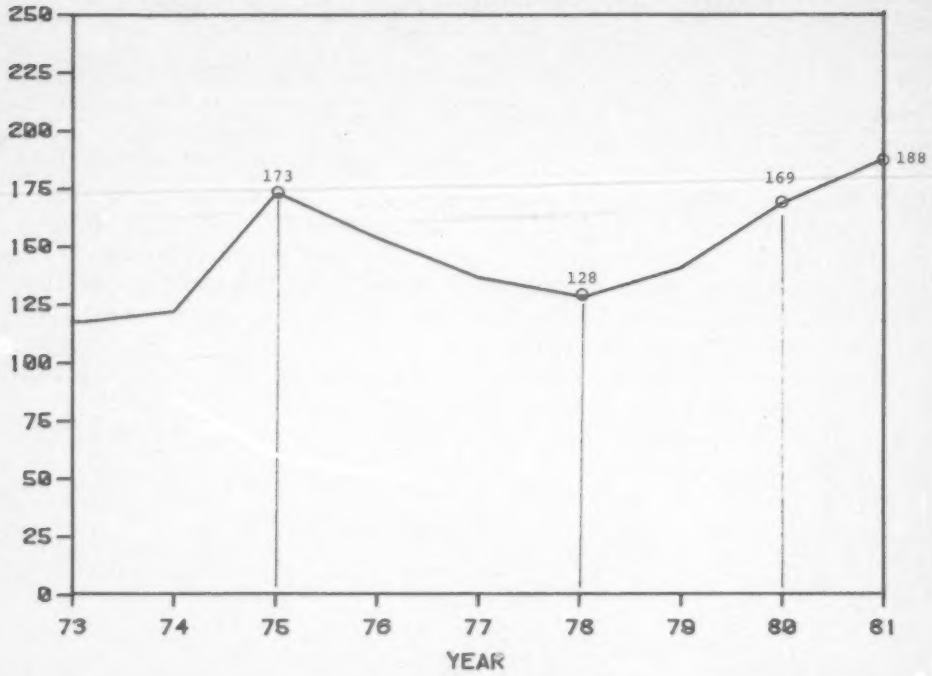


CHART 7

DISABILITY INSURANCE PROGRAM

HEARINGS PENDING PER ALJ



According to the Director of the Office of Hearings and Appeals, SSA intends to approach the problem of the rising caseload in two ways: Increasing the productivity of the staff carrying out the hearing process, while increasing the size of the hearing office staff. In testimony submitted before the House Social Security Subcommittee in October 1981 SSA stated:

> Large numbers of both ALJs and support personnel are needed for the hearing offices. We will hire more than 100 additional ALJs this year, expanding and maintaining the size of the corps to 800 members. Under current practices, of course, we only use OPM-certified ALJs for hearing and deciding cases. . . .
>
> We will also hire additional employees to fill support positions to raise the national level of support staff to ALJs from its present level of 4.5:1 to 5:1. These additional employees will further permit ALJs to devote their time almost exclusively to hearing and deciding cases.
>
> In the last six years, the number of ALJs has increased by approximately 17 percent. During the same period of time, the number of dispositions per ALJ has doubled. In fiscal year 1975, the average ALJ disposition rate was 16 cases per month. During the first eleven months of fiscal year 1981, it was 32 per month. Even with an additional 100 ALJ's we estimate that caseload increases will require an average disposition rate of about 45 cases a month per ALJ.

Prior efforts of the Office of Hearings and Appeals to "increase ALJ productivity" have often proved to be highly controversial with the ALJ's. Establishing case processing goals and trying to influence staffing patterns in individual ALJ operations have prompted charges by judges that their independence was being undermined and that such moves would or could affect adversely the quality of their decisions.

The ALJ decision-making process still remains highly individualized. The ALJ's develop and decide cases in very different ways. They differ markedly in the way they use support staff. Some ALJ's write their own decisions, while some delegate this function to a hearing assistant, or others to a staff attorney. Some ALJ's play a major role in developing cases while others rely on support staff to do this. Some rely heavily on the use of medical consultative examinations, while some make less use of this possible source of additional evidence. ALJ's also vary in the use they make of the expertise of vocational specialists.

Production rates for ALJ's also vary considerably as illustrated in the following table. About 16 percent of ALJ's processed fewer than 300 cases a year in fiscal year 1981; 39 percent processed more than 400.

TABLE 26.—ALJ PRODUCTION RATES—FISCAL YEAR 1981 [1]

Total cases processed	Number of ALJ's	Percent of ALJ's
0 to 300 cases	95	16
301 to 350 cases	115	19
351 to 400 cases	159	26
401 to 450 cases	116	19
451 to 500 cases	64	10
501 cases and above	63	10
Total	612	100

[1] Includes only those ALJ's who were fully trained and on duty the entire fiscal year.

Source: Social Security Administration.

ALJ's have also been subject to criticism for the relatively wide variation in their reversal rates. As shown in Table 27, during fiscal year 1980, 34 percent of ALJ's awarded claims to 49.9 percent or less of the disabled workers whose cases they decided, 51 percent of ALJ's awarded claims to from 50 to 69.9 percent, and 15 percent of ALJ's awarded claims to 70 percent or more. As noted earlier, the percentage of hearings that result in a reversal (an allowance of benefits) has been increasing. In 1970 the DI reversal rate was 42 percent. The ALJ reversal rate increased to 49 percent in 1975 and by 1978, it increased to more than half, or 51 percent of all cases (see Table 20). In 1980 the ALJ allowance rate reached an all time high of 58 percent. The most recent data from the Office of Hearings and Appeals indicates that it may now be declining.

TABLE 27.—REVERSAL RATES OF ADMINISTRATIVE LAW JUDGES, FISCAL YEAR 1980

Reversal rate in percent	Number of ALJs [1]	Percent of all ALJs
0 to 9.9	1	.....
10 to 19.9	3	1
20 to 29.9	17	3
30 to 39.9	50	8
40 to 49.9	129	22
50 to 59.9	157	26
60 to 69.9	150	25
70 to 79.9	69	12
80 to 89.9	18	3
90 to 100	1	.....

[1] Based on the 595 ALJ's on duty for the full year.

Source: Ways and Means Committee Print 97–3, "Status of the Disability Insurance Program," March 16, 1981.

VIII. GENERAL DESCRIPTION OF THE DISABILITY DETERMINATION PROCESS AND PROCEDURES

A. The Definition of Disability

The Social Security Act contains a strict definition of disability that is based on not only the severity of the disabling condition, but also its impact on the individual's ability to work. "Disability" is defined in the Act as the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that has lasted, or is expected to last, at least 12 months, or is expected to result in death. The determination must be made on the basis of medically acceptable clinical and laboratory diagnostic techniques.

The 1972 amendments, which established the SSI program, provided for the use of this same definition. (Some small changes were made for SSI by the 1980 amendments as to what constitutes "substantial gainful activity".) Thus, persons applying for disability benefits must generally meet the same definition of disability under both the social security DI program and the SSI program.

The definition of disability, in title II of the Social Security Act, reads as follows:

SEC. 223 * * *

(d)(1) The term "disability" means—

(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months; or

(B) in the case of an individual who has attained the age of 55 and is blind (within the meaning of "blindness" as defined in section 216(i)(1)), inability by reason of such blindness to engage in substantial gainful activity requiring skills or abilities comparable to those of any gainful activity in which he has previously engaged with some regularity and over a substantial period of time.

(2) For purposes of paragraph (1)(A)—

(A) an individual (except a widow, surviving divorced wife, or widower for purposes of section 202 (e) or (f)) shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he

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lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(B) a widow, surviving divorced wife, or widower shall not be determined to be under a disability (for purposes of section 202(e) or (f), unless his or her physical or mental impairment or impairments are of a level of severity which under regulations prescribed by the Secretary is deemed to be sufficient to preclude an individual from engaging in any gainful activity.

(3) For purposes of this subsection, a "physical or mental impairment" is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(4) The Secretary shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. No individual who is blind shall be regarded as having demonstrated an ability to engage in substantial gainful activity on the basis of earnings that do not exceed the exempt amount under section 203(f)(8) which is applicable to individuals described in subparagraph (D) thereof. Notwithstanding the provisions of paragraph (2), an individual whose services or earnings meet such criteria shall, except for purposes of section 222(c), be found not to be disabled.

(5) An individual shall not be considered to be under a disability unless he furnishes such medical and other evidence of the existence thereof as the Secretary may require.

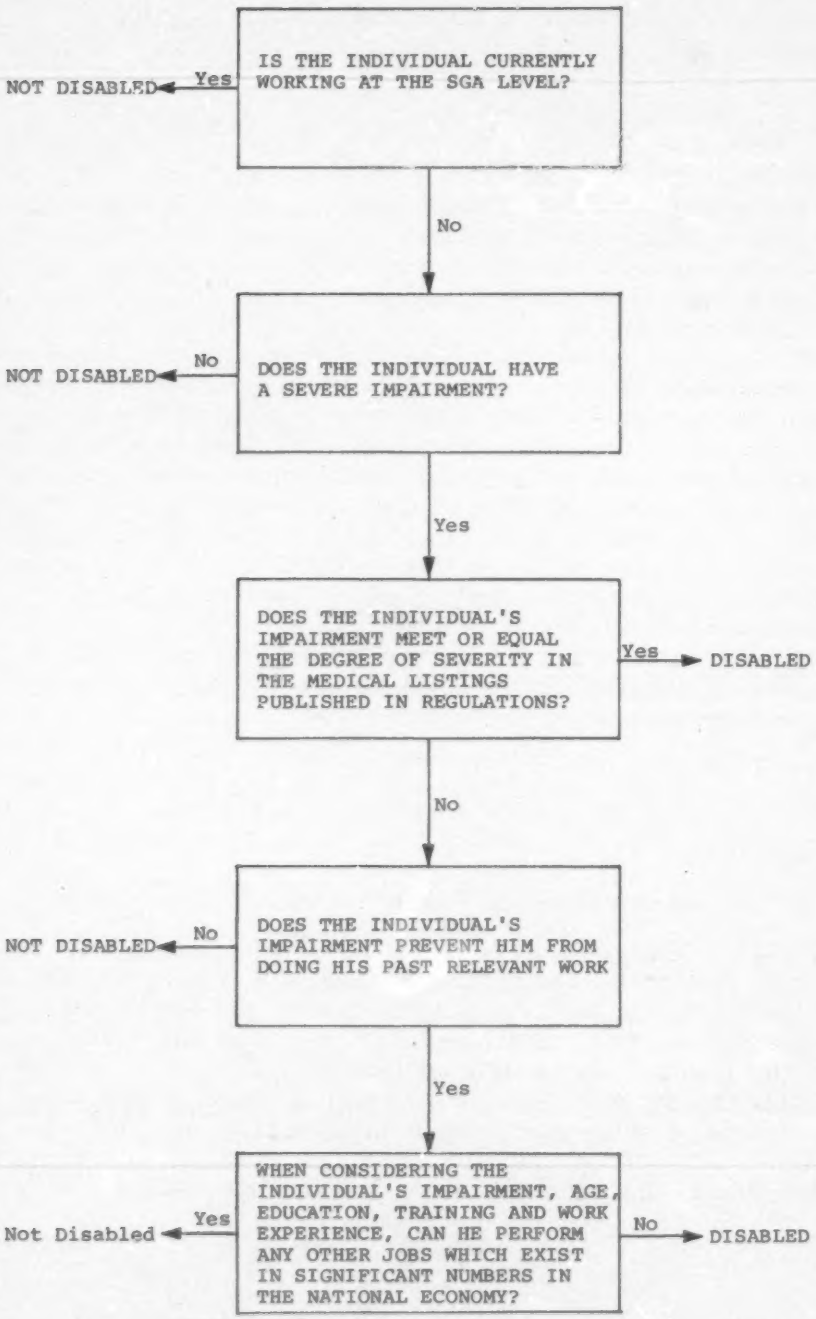
The State agencies, administrative law judges, and others involved in disability decision-making are directed how to apply the definition of disability by detailed Federal regulations, rulings, and administrative policy guidelines.

B. The Sequential Steps Taken in Determining Disability

In making the disability determination, the adjudicator is required to look at all the pertinent facts of a particular case. Current work activity, severity of impairment, and vocational factors are assessed in that order. (See chart 8.) Detailed regulations set forth the medical and vocational factors that must be considered, and state that when a determination can be made at any step, evaluation under a subsequent step is unnecessary. As a result, a disability determination may be based on medical considerations alone, or on medical considerations and vocational factors.

CHART 8

THE DISABILITY DECISION:
A SEQUENTIAL EVALUATION PROCESS


IS THE INDIVIDUAL CURRENTLY WORKING AT THE SGA LEVEL?
Yes
NOT DISABLED
No
DOES THE INDIVIDUAL HAVE A SEVERE IMPAIRMENT?
No
NOT DISABLED
Yes
DOES THE INDIVIDUAL'S IMPAIRMENT MEET OR EQUAL THE DEGREE OF SEVERITY IN THE MEDICAL LISTINGS PUBLISHED IN REGULATIONS?
Yes
DISABLED
No
DOES THE INDIVIDUAL'S IMPAIRMENT PREVENT HIM FROM DOING HIS PAST RELEVANT WORK
No
NOT DISABLED
Yes
WHEN CONSIDERING THE INDIVIDUAL'S IMPAIRMENT, AGE, EDUCATION, TRAINING AND WORK EXPERIENCE, CAN HE PERFORM ANY OTHER JOBS WHICH EXIST IN SIGNIFICANT NUMBERS IN THE NATIONAL ECONOMY?
Yes
Not Disabled
No
DISABLED

Step 1: The first step is to determine whether the individual is currently engaging in substantial gainful activity (SGA). Under present administrative practice, if an individual is actually earning more than $300 per month he is considered to be engaging in substantial gainful activity. Earnings below $190 a month are generally regarded as not constituting SGA. Earnings between these two amounts must be evaluated further. If it is determined that the individual is engaging in substantial gainful activity, a finding is made that the individual is not disabled (and benefits are either denied or terminated) without consideration of medical or vocational factors.

Step 2: If an individual is not engaging in substantial gainful activity, the second step is to assess whether the individual has a severe impairment. Under the regulations, if an individual is found not to have an impairment which significantly limits his physical or mental capacity to perform basic work-related functions, a finding must be made that there is not a severe impairment and that the individual is not disabled. Vocational factors are not to be considered in such cases.

Step 3: If the individual is found to have a severe impairment, the next step is to determine whether the impairment meets or equals the medical listings which have been developed by the Social Security Administration for use in determining whether a condition constitutes a disability. If the impairment meets the 12-month duration requirement and is included in the medical listings—in which case it "meets" the listings—or if the impairment is determined to be medically the equivalent of a listed impairment—it "equals the listings"—a finding of disability must be made without consideration of vocational factors.

Step 4: In cases where a finding of "disability" or "no disability" cannot be made based on the substantial gainful activity test or on medical considerations alone, but the individual does have a severe impairment, the individual's residual functional capacity and the physical and mental demands of his past relevant work must be evaluated. If the impairment does not prevent the individual from meeting the demands of past relevant work, there must be a finding that the individual is not disabled.

Step 5: The final step is consideration of whether the individual's impairment prevents other work. If the individual cannot perform any past relevant work because of a severe impairment, but he is able to meet the physical and mental demands of a significant number of jobs (in one or more occupations) in the national economy, and the individual has the vocational capabilities (considering age, education and prior work experience) to make an adjustment to work different from that which he has performed in the past, it must be determined that the individual is not disabled. If these conditions are not met, there must be a determination of disability.

C. Case Development

1. INITIAL CLAIMS DEVELOPMENT

The development of evidence to support or refute a claimant's allegation of disability begins with the initial interview conducted at the time the application for DI benefits is filed. (See Chart 9.) In the Social Security Administration district office the claims representative records information pertaining to the claimant's work history in order to establish whether or not the claimant has sufficient quarters of coverage to be insured for DI benefits. At the same time, the SSA staff person either completes or assists the claimant in completing a "Disability Report" form (reprinted in Appendix C). This form has the following parts:

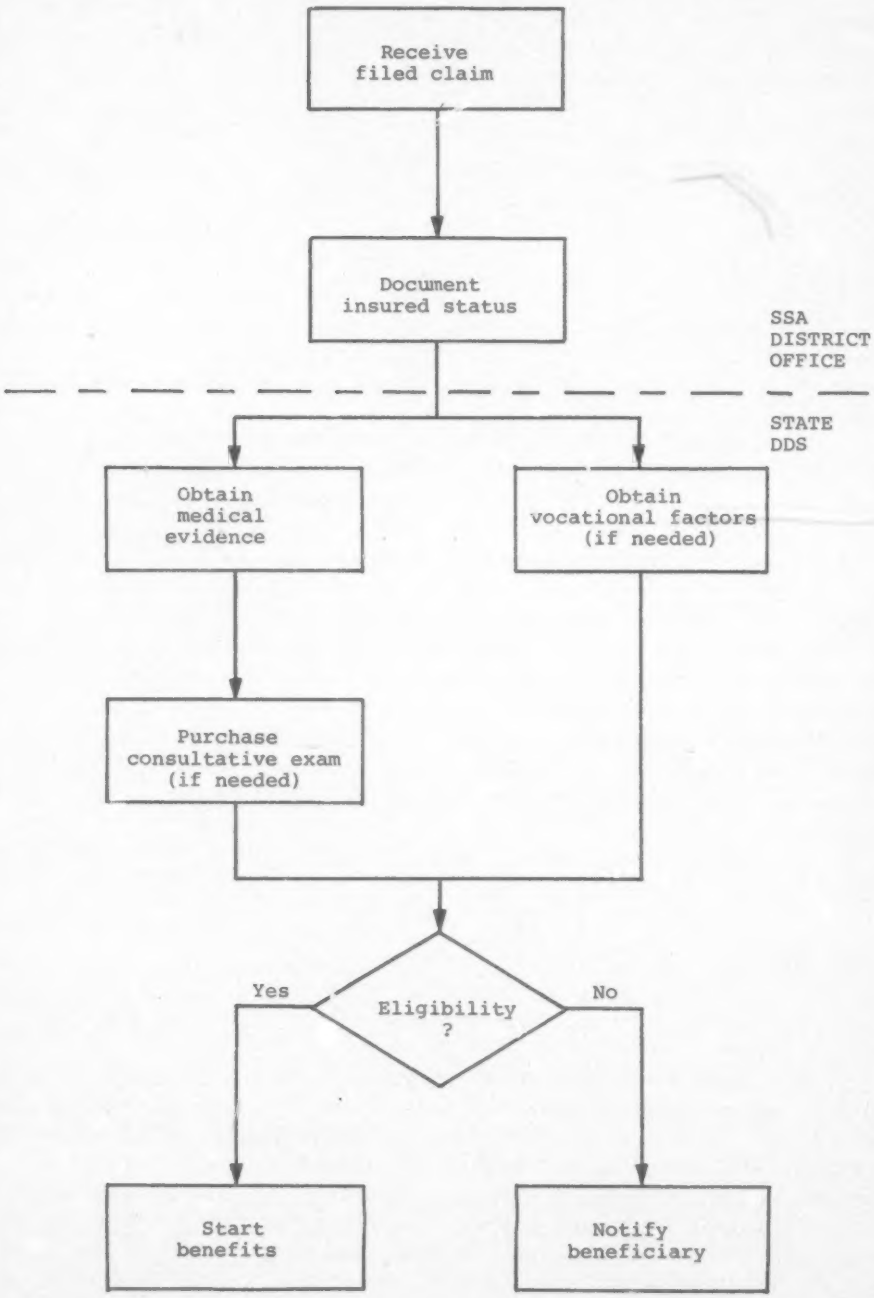
- Claimant's statements with regard to the nature of his or her illness or injury, and the limitations imposed by illness or injury, including limitations on work activity.
- Information about medical treatment and possible sources of medical records.
- Information about daily activities (e.g., shopping, visiting, driving a car).
- Information about education and training.
- Work history for the past 15 years.
- Any additional information the claimant believes may be useful in evaluating the existence of a disabling condition.
- SSA claims representative's observations as to apparent physical or mental impairments including possible need for some other person to assist claimant in pursuing his or her claim.

Unless there is serious doubt about the claimant's insured status or ability to meet other nondisability eligibility requirements, the disability report form is forwarded immediately to the State disability determination service so that development of medical evidence can begin. In the meantime, the social security district office obtains the worker's earnings record in order to document insured status.

State agency personnel in the disability determination service then make every effort to obtain "medical evidence of record" from the claimant's own attending physician, from hospitals, laboratories, clinics, vocational rehabilitation agencies, or from the records kept by other Federal or State programs. In addition, information may be sought from health practitioners other than physicians—psychologists, optometrists, audiologists, chiropractors, etc. In communities where a qualified psychologist or psychiatrist is not readily available, an intelligence test administered by a vocational rehabilitation counselor, educational psychologist, etc. may be acceptable as evidence of severe mental deficiency.

CHART 9

INITIAL ELIGIBILITY DETERMINATION PROCESS



The claimant's own attending or treating physician is usually the primary source of medical evidence. The disability determination service contacts physicians and hospitals either by mail or by telephone and explains the need for the claimant's medical records and the availability of reimbursement from the Government for the costs of photocopying and postage. If for some reason beyond the claimant's control, such as the death or noncooperation of his physician, he is unable to obtain medical evidence, SSA may purchase an examination for him—but only if there is no other evidence of a severe impairment in the file.

If the disability determination service finds the medical evidence obtained from the claimant's physician and other sources to be insufficient or inconclusive, given the specific kinds of information needed with respect to the alleged impairments, then the State can hire a physician to conduct an additional medical examination, called a "consultative examination." This may be only a limited supplemental medical test or a full-scale examination, depending on the completeness of the material already in the claimant's file. According to the operating instructions issued by SSA, the claimant's doctor "is ordinarily the preferred source" of consultative examinations, although he is not used if: (1) he prefers not to do the examination; (2) the claimant prefers another doctor; (3) the physician's reliability or competence is in doubt; (4) evidence from the attending physician will not help to resolve discrepancies in the file; or in certain other circumstances.

State agency personnel contact both the physician and the claimant in order to arrange for the examination, explaining to each what is expected of him. If the claimant refuses to report for the examination, his claim is not automatically denied, but is decided based on the other evidence in the file. Claimants who are too ill to travel may be examined in their homes or in institutions. In practice, States purchased consultative examinations in 39.5 percent of initial determinations (DI, SSI, and concurrent) conducted from October 1, 1981 through May 28, 1982 and this rate has been increasing.

In addition to the medical evidence of record obtained by the State agency (sometimes with the help of the social security district office or the claimant himself), any additional evidence submitted on the initiative of the claimant is included in the file. It is taken into consideration in the determination of disability, although the cost of providing such evidence is reimbursable only if the State agency finds the unsolicited evidence "useful in adjudication" of the claim.

At the same time that medical evidence is being sought, the disability determination service will decide, based on the circumstances of the case, whether detailed information about vocational factors—age, education, and work experience—is likely to be needed in order to reach a final decision. If so, the claimant is contacted, usually by telephone, and asked to provide answers to questions listed on a "Vocational Report" form (reprinted in the Appendix C). This form contains detailed questions about the specific jobs held by the claimant (in most cases during the prior 15 years) and the physical and mental demands of those jobs. The claimant is also given the opportunity to make any additional remarks he or

she may want to about his work history or other circumstances relating to his disability claim. If judged necessary in order to complete the picture of the claimant's work history and capacity to work, evidence can be sought from vocational rehabilitation counselors or independent vocational consultants.

If the State disability determination service denies the claim, either at the initial level or upon reconsideration, additional medical and/or vocational evidence may be sought by officials reviewing the case or provided by the applicant as it moves through the appeal process.

The procedures used in title XVI SSI disability cases or in concurrent cases are very similar. In SSI, claimants may be able to receive benefits based on a finding of "presumptive disability" if their impairments, as reported by the applicant or as observed by the social security district office personnel, are so severe that a finding of disability seems almost certain. Benefits based on presumptive disability can only be paid if all nondisability eligibility requirements have been met and must end as soon as the State agency makes its disability determination or after three months, whichever comes first. Presumptive disability payments allow certain severely disabled needy individuals to receive assistance while the normal medical evidence gathering and evaluation procedures described above are under way in the State disability determination service. They are not subject to repayment, even if the claimant is ultimately found not to be disabled.

2. CONTINUING DISABILITY CASE DEVELOPMENT

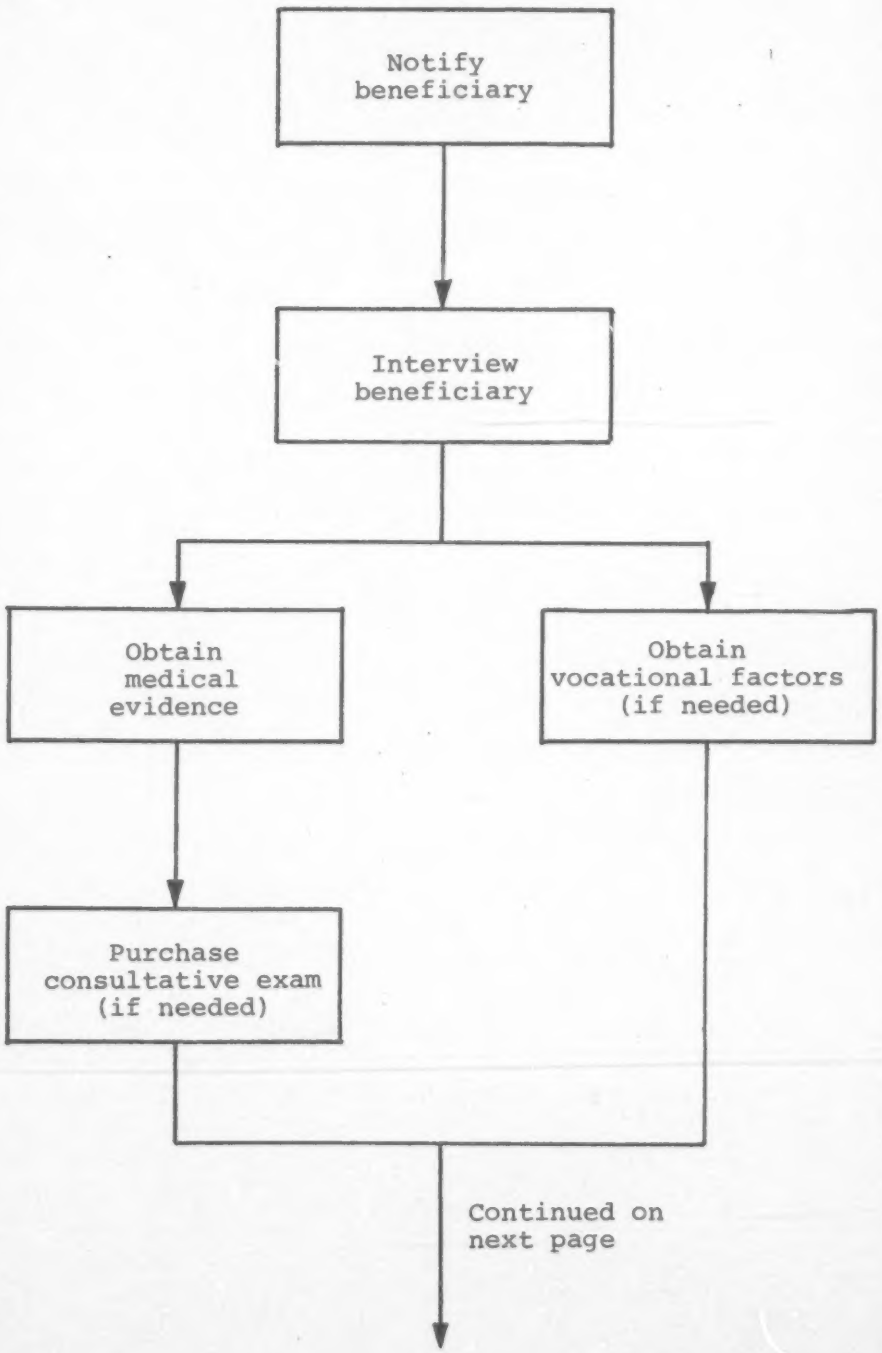
According to SSA guidelines, "the development process and evidentiary requirements that apply in determining initial disability also apply in determining whether disability continues, however, the development of medical evidence is basically an updating process." When a beneficiary has been selected for a continuing disability investigation, he is usually contacted first either by telephone or by mail. (See Chart 10.) If the contact is made by telephone, a State agency staff person explains the reason for the review and the possibility that benefits may be terminated if the individual's condition is no longer disabling and asks a series of questions the answers to which are recorded on a "Report of Continuing Disability Interview" form (reprinted in Appendix C). This form contains questions pertaining to:

- Medical care and treatment, periods of home confinement, and school attendance (for disabled children).
- Daily activities, such as walking, household chores, etc.
- Changes in condition, including ability to return to work.
- Efforts to work, if any.
- Participation in vocational rehabilitation.

- Any additional comments the beneficiary would like to make with respect to his continuing disability.
- In the relatively rare case in which the SSA district office assists the beneficiary in completing the form, the SSA staff person's observations about the appearance and behavior of the beneficiary that may bear on his continuing disability.

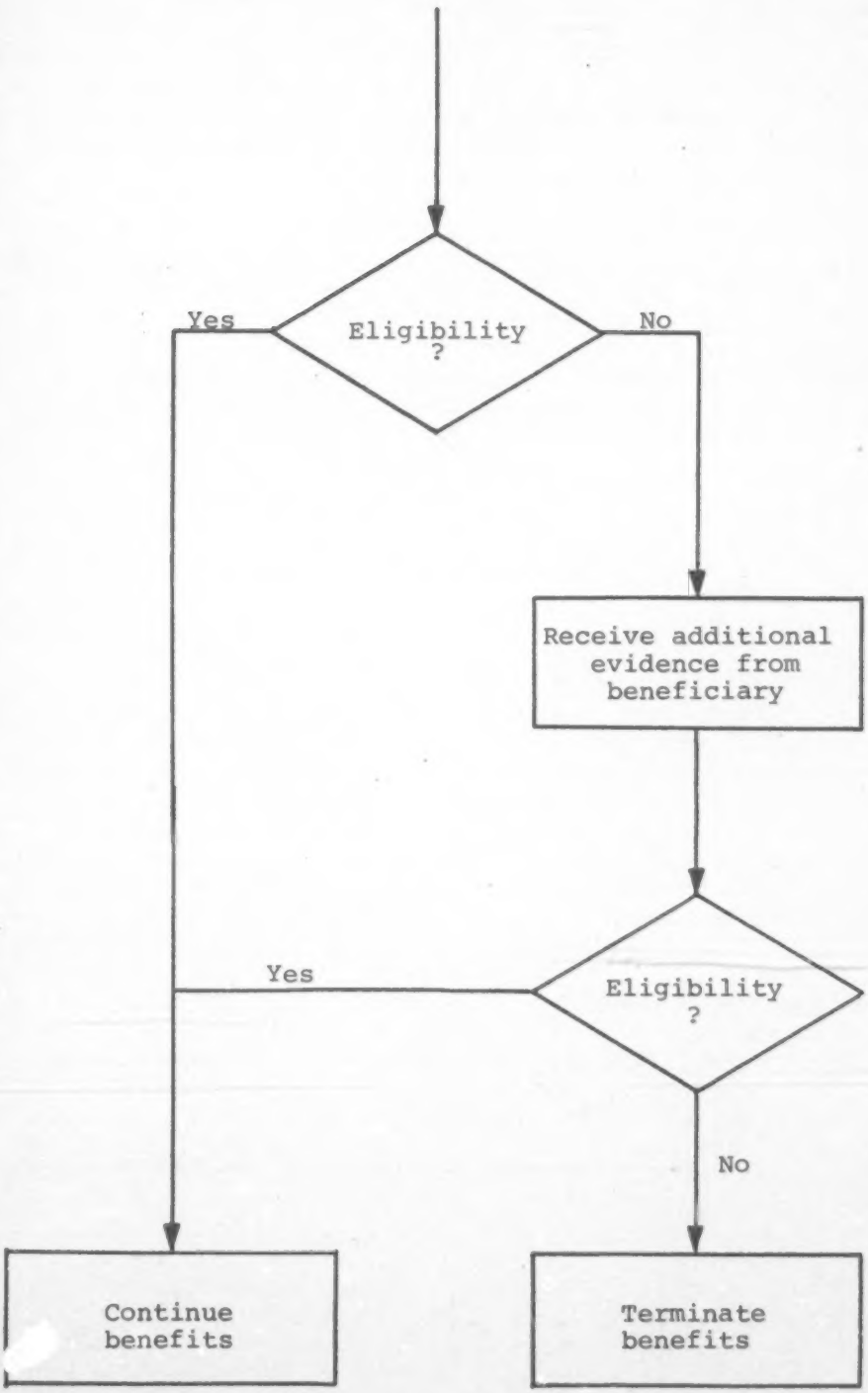
CHART 10

CONTINUING DISABILITY INVESTIGATIONS PROCESS



CONTINUING DISABILITY INVESTIGATIONS PROCESS

(continued)



When the form has been completed, a copy is forwarded to the individual for him to make any needed revisions, sign, and return. If the information is obtained by mail, a similar form called a "Social Security Disabled Person Report" is used. If the form is not returned promptly (within about 10 days), the State agency follows up by calling or writing the claimant. If their follow-up efforts are unsuccessful, the social security district office is asked to help. SSA guidelines require that "attention be given to the possibility that the very nature of the beneficiary's impairment may be a valid reason for preventing cooperation." In such cases if evidence in the file supports that fact, benefits may be continued. However, failure of the beneficiary to cooperate in obtaining current medical evidence usually results in a cessation of benefits.

In continuing disability reviews, the State agency seeks medical evidence from all sources which have treated the individual during the past year, before soliciting or purchasing other medical evidence. If additional medical evidence is needed, the State agency next seeks out and purchases medical evidence of record—a report of a recent examination conducted by the beneficiary's physician, or by a hospital, clinic, etc. In addition, the beneficiary may submit unsolicited medical evidence. Such evidence is considered, insofar as it does not simply duplicate other evidence in the file, but the costs of providing it are only reimbursable if the unsolicited evidence is useful in adjudicating the claim.

When there is a conflict between the medical evidence of record and the individual's statements, or if the available evidence is not sufficiently detailed, a consultative examination is obtained. As in initial determinations of disability, the beneficiary's own attending physician can be given preferred consideration in the selection of a physician to conduct a new medical examination as part of a continuing disability review. The State agency is required to explain to the physician that his report could be the basis for a decision that would result in the termination of his patient's disability benefits. When the attending physician objects to performing the examination, other examination sources are sought. According to the Social Security Administration, State agencies purchased consultative examinations for 55.5 percent of the continuing disability investigations conducted from October 1, 1981 through May 28, 1982 (including DI, SSI, and concurrent cases). (In practice, program officials feel that consultative examinations are most often purchased from sources other than the treating physician.)

Development of vocational information may be very important in a continuing disability investigation, even if vocational factors were not involved in the original determination of disability. In order to complete the vocational development, the State agency must obtain a complete history of the beneficiary's work activity for the 15 years prior to the time of the continuing disability investigation. This may require only an updating of material already in the file or completely new information. This information may be obtained from the beneficiary, from a vocational rehabilitation agency, or occasionally from other sources. In addition, the State agency must investigate whether the beneficiary is participating in vocational rehabilitation, since under the 1980 amendments there are circumstances under which benefits may continue after the impairment

ceases, if the beneficiary is participating in an approved VR program.

The development of medical and vocational evidence in SSI and concurrent DI/SSI continuing disability reviews is very similar to the process described above for DI cases. Information from the current treatment facility is to be obtained when drug addicts and alcoholics on SSI are subject to a continuing disability review. Participation in a treatment program does not necessarily mean that the recipient is either disabled or not disabled under the law.

Under SSA's due process procedures, beneficiaries are given an additional opportunity to submit evidence of their continuing disability if the decision has been made that they are no longer eligible to receive DI benefits. Notices of SSA's intent to terminate benefits are also sent to beneficiaries who have failed to cooperate in the investigation and to beneficiaries whose allegations about their condition conflict with the medical and vocational evidence. SSA gives fifteen days after mailing a written notice for the beneficiary to respond in writing; if he or she indicates a desire to obtain and submit additional evidence, he or she may be granted an additional 10 days to do so. After this evidence has been evaluated, a formal determination is sent to the beneficiary stating whether benefits will cease or continue.

If benefits are terminated, both the beneficiary and the officials receiving the case on appeal may obtain additional medical and vocational evidence at any stage of the appeal process—prior to reaching the Appeals Council.

Due process procedures are somewhat different for SSI and concurrent cases. The most important difference is that in SSI cases, because of the Supreme Court decision in *Goldberg* v. *Kelly,* benefits may not be terminated for medical reasons until the beneficiary has been given an opportunity for an oral evidentiary hearing. In such cases, there is no formal reconsideration, but the case may proceed directly to an ALJ, where the beneficiary has the opportunity to submit additional evidence. This continuation of benefits is required because SSI payments are based on need.

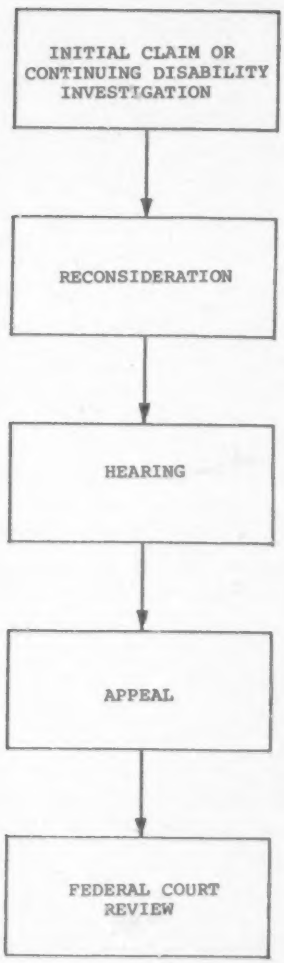
D. Initial and Appellate Stages of Decision-Making

The disability claims process is identical for applicants of both DI and SSI. Briefly, an applicant files his claim at a local social security office. The information taken at the social security office is sent on to a State disability agency, which determines on the basis of this and any additional evidence it may require whether the person meets the definition of disability. If the claim is denied, it is reconsidered by the State agency, upon request of the claimant. A claim which is denied at the reconsideration level may, upon appeal, receive a hearing by an administrative law judge (ALJ). If the ALJ denies the claim, an additional level of appeal can be made to the Social Security Administration's Appeals Council. And, finally, if still dissatisfied, a claimant may appeal the decision in a Federal district court. Thus, the determination of whether an individual meets the definition of disability may involve five different steps, including four levels of appeal. (See Chart 11.)

Other DI and SSI claims (old age and survivors insurance and SSI claims on the basis of age) follow the same steps, excluding, of course, the State agency determination of disability. However, more than 95 percent of the claims that proceed through the appeals system involve the issue of disability. Therefore, whenever the claims and appeals process is criticized on the basis of quality of decisions, complexity of system, and length of process, it is ordinarily a disability case that is involved.

CHART 11

STAGES OF DISABILITY DECISION-MAKING



	Administered by:	Time allowed to request next stage	Average time from request to decision 1/
INITIAL CLAIM OR CONTINUING DISABILITY INVESTIGATION	SSA District Office or State Agency (DDS)*	60 days	46 days
RECONSIDERATION	State Agency (DDS)*	60 days	39 days
HEARING	SSA's Administrative Law Judges	60 days	165 days
APPEAL	SSA's Appeals Council	60 days	66 days 2/
FEDERAL COURT REVIEW	Federal Court System	--	Not Available

*Disability Determination Service.

1/ For DI cases including the DI portion of a concurrent case.

2/ Includes DI, OASI, SSI and Black Lung cases.

In recent years, the system has had to handle a vastly larger caseload than was the case in the early years of the program. In 1962, for example, there were about 440,000 disabled worker applications received in social security district offices. In fiscal year 1982, there will be about 1.3 million DI cases, and more than 1.1 million SSI disability and blindness applications of which 30 percent are expected to be appealed. The structure and procedures of each decision level are discussed briefly in this section.

1. INITIAL DETERMINATION BY SSA DISTRICT OFFICES AND STATE AGENCIES

Applications for DI and SSI disability benefits are filed by claimants in one of SSA's district offices. The district offices accept applications, obtain the names of the physicians, hospitals or clinics that have treated the claimants, and make all the nonmedical eligibility determinations based on such factors as insured status, work activity, and for SSI claims, income and resources. If the claim is denied because the applicant does not meet these nonmedical eligibility requirements, a formal notice is sent.

A claimant's application, any medical records he or she may have provided, lists of sources of medical evidence, and other background information obtained during the district office interview are forwarded to the disability determination service (DDS) in the individual's home state. The DDS's are State agencies and are usually components of State vocational rehabilitation agencies. Their total operating costs are paid by SSA.

As previously explained, the DDS requests detailed medical reports from physicians who have treated the claimant/beneficiary. These reports largely consist of clinical and laboratory findings in the files of treating physicians. However, if sufficient medical information cannot be obtained in this manner, the DDS may purchase a consultative examination—that is, ask the claimant to be seen by a private physician selected by the DDS. The DDS may also seek more information pertaining to the claimant's education and work experience from the claimant.

After the required evidence has been obtained, a two-person DDS team consisting of a physician and a lay disability examiner makes a decision on the claim. The DDS physician determines from the medical evidence the extent to which physical or mental limitations exist and whether the impairment meets or equals the medical listings published in regulations. (The medical listings and vocational factors are discussed in Section IX of this print.) The medical listings describe specific diagnostic signs, symptoms, and clinical laboratory findings for various common impairments which are considered severe enough to prevent a person from doing any gainful activity on an ongoing basis. If the claimant is not found to be disabled on the basis of the medical criteria in the listings, a determination is made of the claimant's physical and mental ability to perform various types of work-related functions.

The DDS lay examiner determines whether, with those limitations, the claimant can or cannot perform substantial gainful activity in jobs that exist in the national economy, based on the claimant's age, education, and work experience. DDS determinations are

then issued as Federal decisions and the claimant is notified of the decision. The average time for processing a DI claim—from receipt of application through the initial determination—is 46 days. If the claim is denied, the formal notice indicates why and advises the applicant of his or her appeal rights.

If the decision is to terminate benefits of an existing beneficiary, benefits are payable for the month in which the disability ceased or was found not to exist, and for 2 additional months. Under a procedure recently adopted by the Administration, which applies in cases of medical determinations, benefits are now being paid for the month in which the reviewed beneficiary receives notification that he no longer meets the eligibility requirements (the month of cessation) and for 2 additional months. He or she is not held accountable for overpayments prior to the time of review and notification.

2. RECONSIDERATION BY STATE AGENCIES

Claimants whose applications are denied, as well as beneficiaries who have been terminated, have a right to have their claims reconsidered. They must file for reconsideration within 60 days after receiving notice of the denial. The reconsideration decision is also made by the DDS. The reconsideration decision process is similar to the initial disability decision process except that, after the district office updates the claimant's file, a different DDS team from that which made the original denial reviews the claim. New evidence is admissible, as it is at any stage of appeals prior to the Appeals Council. If denied again, the claimant is given notice and advised of further appeal rights. The average time for processing a DI reconsideration request is 39 days.

Amendments in 1976 reduced the period for requesting reconsideration from 6 months to 60 days. Since then, the number of decisions reversed on reconsideration has declined sharply, although many other factors could have contributed to this decline.

3. HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE

If the DDS reconsideration team upholds the initial denial or termination, the claimant may request a formal hearing before an administrative law judge in the SSA Office of Hearings and Appeals (OHA). A request for the hearing must be filed within 60 days after receiving notice of the reconsideration determination. These requests are forwarded to one of SSA's hearing offices located across the Nation and are assigned to individual ALJ's.

The ALJ is responsible for perfecting the evidentiary record, holding face-to-face nonadversary hearings and issuing decisions. At the hearing, the claimant appears for the first time before a decision-maker. The ALJ may request the appearance of medical and vocational experts at the hearing and can require claimants to undergo consultative medical examinations. Claimants may submit additional evidence, produce witnesses, and be represented by legal counsel or lay persons. There is no charge for requesting a hearing. The average time for processing a hearing request for a DI case is currently 165 days.

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4. APPEALS COUNCIL REVIEW

Following an ALJ decision to deny a claim, the claimant may, within 60 days after receiving notice, request the Appeals Council to review the decision. The Appeals Council is a 15-member body located in the Office of Hearings and Appeals. The Appeals Council may deny or grant a request for review of an ALJ action. If the Council agrees to review, it may uphold or change the ALJ action or it may remand the case back to an ALJ for further consideration. It may also review any ALJ action on its own initiative (commonly referred to as "own motion review") within 60 days after the date of the ALJ action. The Appeals Council review represents the Secretary's final decision and is the claimant's last administrative remedy. The average time for an appeal decision is 66 days.

5. FEDERAL DISTRICT COURT

If the Appeals Council affirms the denial of benefits or refuses to review the case, further appeal may only be made through the Federal district courts.

Increasingly, reversal of the Agency's final decision is being pursued in a U.S. district court. Between 1955 and 1970, the total number of disability appeals filed with Federal district courts was slightly under 10,000 cases. In 1981 alone, approximately 9,000 disability cases were appealed to the district court level. As of June 30, 1982, there were 20,000 disability (DI and SSI) cases pending in the Federal court system.

Caseload and actions at various stages of decisionmaking

As illustrated in Chart 12, there were 985,801 initial DI determinations in fiscal year 1981. Of these, 30 percent were allowed and 70 percent were denied. Approximately 49 percent of those denied asked for a reconsideration by the State agency; 29 percent requested a reconsideration and then a hearing before an ALJ; 1 percent appealed their denial all the way to the U.S. district courts.

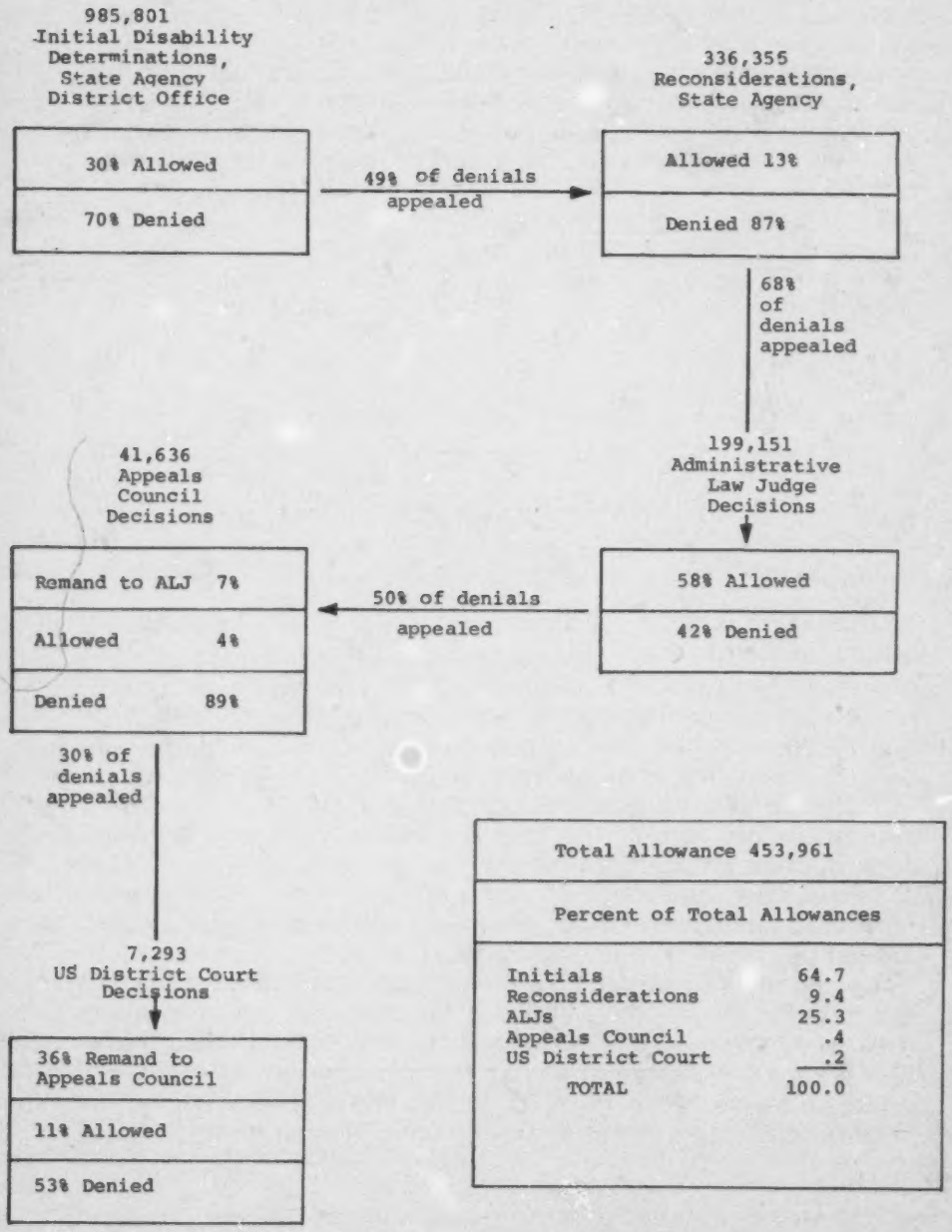
Of the 453,961 allowances in fiscal year 1981, 64.7 percent were allowed at the time of the initial determination; 9.4 percent were allowed upon reconsideration by the State agency; 25.3 percent of all allowances were made by the administrative law judges and the remaining small percent of allowances were made by the Appeals Council and the U.S. district courts.

The average processing time for initial DI determinations was 46.3 days in June, 1982. For the same month, DI reconsideration cases were, on average, processed in 38.9 days. During May, 1982 the average processing times at the hearing level for DI, SSI and concurrent cases were 165, 176, and 180 days respectively.

Comparable data is not available for CDI cases alone.

CHART 12

TITLE II
DISABILITY DETERMINATIONS AND APPEALS
FOR INITIAL APPLICATIONS *
FISCAL YEAR 1981



Total Allowance 453,961	
Percent of Total Allowances	
Initials	64.7
Reconsiderations	9.4
ALJs	25.3
Appeals Council	.4
US District Court	.2
TOTAL	100.0

*Include concurrent title II and Title XVI. Rates of appeal are based on total decisions made, not on receipts during fiscal year.

E. Key SSA Organizational Responsibilities

1. The Social Security Administration's district offices: As previously described, claims for disability under either the title II or title XVI program are taken at local social security district offices. There are more than 1,300 district offices (including branch offices) throughout the United States, and they handle more than 7 million claims for benefits under OASDI and SSI each year. More than one-third of the applications are filed by disability claimants. In fiscal year 1980, in addition to claims, 42 million other transactions were processed by district offices.

The manager of a district office has considerable latitude about how to organize the operations of his staff. In recent years, however, SSA has required offices, unless they are too small to make this feasible, to develop specialists among their claims representatives to become expert in either the title II or title XVI program.

The Social Security Administration does not require that there be specialists designated to handle disability cases, although it is clear that in some offices, especially larger offices, there are incentives to encourage individual claims representatives to specialize on an informal basis. Disability cases are generally significantly more complex than other cases, and it requires both skill and patience to conduct a disability interview that is sufficiently thorough to obtain the kinds of information necessary to develop the case.

As previously described, during the interview it is the responsibility of the claims representative to obtain relevant medical and work history from the applicant and to see that the required forms are completed. The way in which this responsibility is handled varies from office to office, and with the circumstances of the individual. In some offices where it is believed that most applicants are capable of filling in the forms themselves, the claims representative may play a relatively passive role of reviewing briefly the form after it is completed. In other offices, the process involves a lengthy interview. In any case, the quality and completeness of the information that is obtained is extremely important in the further processing of the case. On the basis of the interview, the claims representative may determine that the individual is engaging in substantial gainful activity, in which case the individual will be denied benefits without having his case considered further.

2. The State Disability Determination Services: Although both the DI and SSI programs are considered Federal programs and their benefits are financed at the Federal level, the crucial benefit eligibility decision is made by 54 State agencies—the State disability determination services. These State agencies operate under contract with the Social Security Administration, an arrangement which dates to the disability "freeze" amendments of 1954 (whereby the level of social security benefits was protected, rather than eroded, during periods of disability).

The Congress decided that the determination of eligibility for the disability freeze could most logically be performed by State vocational rehabilitation agencies, which would facilitate and ensure referral of disabled individuals for vocational rehabilitation services. The relationship provided in the law was a contractual one, with

State agencies being reimbursed for their administrative expenditures from the DI trust fund.

When the legislation was amended in 1956 to authorize payment of disability benefits, the same Federal-State arrangement was maintained. At the same time the Secretary of Health and Human Services was given the authority to reverse the State agencies' determinations that workers were qualified for benefits, in order to protect the trust fund from excessive costs and to promote more uniform decisions throughout the country.

This Federal-State arrangement is unique among government programs. State laws and practices control most aspects of administration, and the personnel involved are State employees who are controlled by various departments of the State government. The State agencies make determinations of DI on the basis of standards and regulations provided by the Social Security Administration. The costs of making the determinations and other aspects of related operations are paid wholly from the DI trust fund in the case of the DI program, and from general revenues in the case of the SSI program. No State funds are involved.

According to SSA, an estimated 13,000 non-Federal work-years of effort will be expended by State agencies in fiscal year 1982 at an overall cost of about $552 million (including costs under the DI and SSI disability programs). The major component of the cost is payroll, with the purchase of medical evidence in the form of consultative examinations being the next largest cost.

The role played by the State agencies in the disability determination process can be broken down into three basic functions. Using criteria established by the Social Security Administration, they: (1) make the initial determination as to whether an individual is disabled, (2) reconsider initial decisions if the claimant believes he has been wrongfully denied, and (3) conduct continuing disability investigations to determine whether individuals should remain on the disability rolls.

The agency's initial decision as to whether an individual meets the criteria for disability is of crucial importance to the entire process. Although a significant percentage of those denied benefits continue through the adjudication process by appeal, the majority of cases are determined at the initial decision level. This decision is made on the basis of a review of the individual's case file. Ordinarily there is no personal interview with the applicant on the part of the State personnel who decide the claim. However, the agency frequently may contact the individual if further medical or vocational information is needed. If medical evidence is insufficient and can be obtained no other way, the agency may request that the individual undergo a consultative medical examination, which is paid for by the agency. (Data is not available concerning the extent to which States actually use treating physicians for the consultative exams.)

When all the evidence considered necessary to make a decision has been gathered, the case is determined by a State disability examiner, in consultation with a State agency physician and, if necessary, a vocational specialist. In all cases, the decision must be signed by the physician.

3. The Social Security Administration's Office of Hearings and Appeals: The Office of Hearings and Appeals (OHA)—formerly known as the Bureau of Hearings and Appeals—within the Social Security Administration is responsible for holding disability hearings. Hearings are held by an administrative law judge who is assigned by OHA to handle the case. There are now over 750 ALJ's handling title II and XVI cases throughout the country. The hearing is generally a claimant's first face-to-face meeting with an individual who is deciding his claim. State agency decisions, as indicated earlier, are ordinarily made on the basis of what is in the claimant's file. At a hearing, however, the individual may present his own case in person, or he may have someone to represent him. The procedure is nonadversarial, and the judge is free to take new evidence, and to call upon expert witnesses concerning the claimant's medical condition and his vocational capabilities.

The hearings held by the administrative law judges are subject to the Administrative Procedure Act of 1946. The Social Security Act, however, with its provisions for hearings predates the Administrative Procedure Act. The Supreme Court commented on this situation in the 1971 case of *Richardson* v. *Perales:*

> We need not decide whether the APA has general application to social security disability claims, for the social security administrative procedure does not vary from that prescribed by the APA. Indeed, the latter is modeled upon the Social Security Act.

The Supreme Court has held in a series of cases that the due process clause of the Constitution protects an individual from final denial of a substantial benefit without opportunity for a hearing. (*Flemming* v. *Nestor,* 1960; *Goldberg* v. *Kelly,* 1970). Moreover, these cases and others have spelled out the procedural components of the hearings which must be present to meet due process requirements, including adequate notice, access to evidence, right to cross examination, right to counsel and written finding, and reasons for the decision. Due process also requires that the person who takes evidence and makes the decision be impartial, that the trier of fact may not be prosecutor in the same matter, and that he may not have been involved in the matter previously as an agency staff person. These also are requirements of the Administrative Procedure Act.

It is in the area of the qualification of the hearing officer and his relationship to the agency adjudicating the claim that the Administrative Procedure Act imposes requirements which are unique. Currently, an ALJ must have seven years of "qualifying experience," must consent to having confidential questionnaires sent to employers, supervisors, law partners, judges, co-counsel and opposing counsel in cases in which he has participated; must demonstrate writing ability by preparing a sample opinion, and must participate in an oral interview by a board composed of an official of the Office of Personnel Management, a practicing attorney from the American Bar Association and an ALJ.

The Administrative Procedure Act was designed to insure the independence of the ALJ from the agency in which he operates by placing his pay, promotion, and tenure under the Office of Person-

nel Management, rather than under the agency whose cases he decides. However, an ALJ is an employee of the agency and is obligated to render decisions in accord with the properly established policies of the agency.

4. The Social Security Administration's Appeals Council: The Appeals Council, which is also a component of the SSA's Office of Hearings and Appeals, is responsible for deciding appeals of cases denied or terminated by ALJ's at the hearing stage. The Appeals Council is also charged with carrying out the requirement that the secretary, on his own motion, review decisions made by ALJ's. The Appeals Council has fourteen members who handle cases according to their assigned geographic areas of the country. The Director of the Office of Hearings and Appeals, serving as Chairman of the Council, is an additional member.

In contrast to the reviews before the administrative law judge, the Appeals Council review is on the basis of a closed record. Any new evidence not previously presented by the claimant, may not be submitted for consideration. Only the file existing after the ALJ hearing decision is admissible. This "closed record" was required by the 1980 disability amendments. For the most part, these reviews are a "paper review" of the case, and thus do not involve a face-to-face presentation of the facts as is done at the hearing stage. The 1980 amendments, however, do permit the Appeals Council to remand a case back to an ALJ "to remedy an insufficiently documented case or other defect."

F. Case Review Process—Preadjudicative, Own-Motion and CDI Reviews

1. REVIEW OF DDS DISABILITY ALLOWANCES

The Disability Amendments of 1980 require that SSA conduct a Federal review of a certain proportion of favorable DI decisions made by State disability determination services (DDS's) before benefit payments begin. This "pre-effectuation review," in which incorrect decisions made by the DDS's may be reversed prior to notification of the claimant or payment of any benefits, is intended to promote the uniformity and accuracy of disability decisions. The review applies to decisions made by the DDS's on initial claims, reconsiderations, and continuing disability investigations.

As mandated by the 1980 amendments, SSA began the program of pre-effectuation review in October 1980. In fiscal year 1982, SSA is required to review 35 percent of all favorable DDS decisions, and 65 percent thereafter. Reviews have been targeted on those types of allowances determined from available data to be most likely in error. Through June 30, 1981 about 17.5 percent of DDS allowances were reviewed by SSA and about 8.5 percent of the cases reviewed were returned to the DDS's, either because the finding of disability was erroneous or because the finding was inadequately documented.

2. OWN-MOTION REVIEW OF ALJ DECISIONS

Beginning in October 1981, SSA implemented an ongoing program of own-motion review. The review is being conducted in the

Office of Hearings and Appeals by the Appeals Council, which has the delegated authority to review ALJ decisions at the request of the claimant or terminated beneficiary or on its own motion (i.e., its own initiative). The own-motion review program concentrates primarily on ALJ disability allowances issued for DI and concurrent DI/SSI claims, and includes both initial and CDI cases.

Currently, a sample of decisions of ALJ's and hearing offices with the highest allowance rates is being selected. These cases are being forwarded directly to OHA's central office in Arlington, Virginia, where they undergo screening and review by staff of the Appeals Council. Where appropriate, referrals are made to the Appeals Council for consideration of own-motion action. Once the Appeals Council decides to review a hearing decision on its own motion, the Council may affirm, reverse, or modify the decision or remand the case back to an administrative law judge for further proceedings.

Current data indicate that the Appeals Council is finding defects in 43 percent of the ALJ decisions they review and are reversing the ALJ decision or remanding the case back to the ALJ in 17 to 18 percent of the cases.

3. CONTINUING DISABILITY REVIEWS

The DDS not only has the function of deciding who comes on the disability rolls, but also must make determinations as to whether individuals stay on the rolls. The continuing disability investigation (CDI) process is SSA's way of identifying beneficiaries who may have medically recovered or regained the ability to work and assessing their continuing eligibility for disability benefits.

As mentioned in Section VI, SSA monitors the eligibility of DI beneficiaries in three ways. One method is the "diary" approach. Typically, if an initial entrant into the program has a condition that is likely to improve, the disability examiner who makes the decision will schedule (or diary) a later re-examination, i.e., a CDI. Typically, this re-examination occurs at yearly intervals. In general, the cases to be "diaried" for medical reexamination are only those involving an impairment which is one of 17 specific impairments. The diary categories include tuberculosis, functional psychotic disorders where onset occurred within the two preceding years, functional nonpsychotic disorders, active rheumatoid arthritis without deformity, cases in which corrective surgery is contemplated, obesity, fractures without severe functional loss or deformity, infections, peripheral neuropathies, sarcoidosis without severe organ damage, probability of progressive neoplastic disease but there is no definitive diagnosis, neoplastic disease which has been treated and incapacitating residuals exist but improvement of the residuals is probable, epilepsy, respiratory disease based on frequency of acute episodes, acute leukemia, central nervous system trauma, and back conditions amenable to treatment. Also included in this category of CDI's are cases where voluntary reports of medical improvement are submitted by beneficiaries.

The second method of monitoring continuing eligibility is when an individual engages in a "trial work period" during which it is determined whether he is able to sustain work activity sufficient to

be considered substantial gainful activity. Also in this category are "work activity" cases in which the agency identifies from earnings reports (from either the beneficiary or the employers) that the beneficiary has returned to work.

Beneficiaries are informed of their responsibility to report events which might have some bearing on their case. This is explained to them orally during the application interview and is repeated in the form of written instructions which are mailed with award notifications. SSA also maintains a control of the earnings record of each individual for whom disability has been established. When appreciable earnings are reported for such an individual, they are examined with the claims file and, if it appears that a question of eligibility exists, an investigation is begun. A beneficiary's return to work may indicate that the impairment has improved or that the individual has the ability to work despite the impairment.

The third method is the periodic review procedure mandated by the Disability Amendments of 1980. As previously described, this method requires SSA to review the eligibility of each disabled-worker beneficiary at least once every 3 years, unless his condition is believed to be of a permanent nature (in which case periodic reviews of eligibility are still mandated, but need not be as frequent). SSA chooses the cases for review based upon profiles, developed through special studies of the characteristics of cases involving nonpermanent disabilities in which beneficiaries are most likely to be ineligible. (These profiles are discussed further in section V of this print.)

As the first step in a CDI, the Social Security Administration transfers the beneficiary's case folder to the State DDS, which notifies the beneficiary that a review will be undertaken. The beneficiary is asked to provide information about the current status of his condition and about when and where he has recently received medical treatment. If the current medical evidence is not detailed enough, or if the beneficiary has had no recent medical treatment, the DDS arranges a consultative examination of the person's present condition.

The DDS then evaluates the medical evidence and determines whether the beneficiary continues to be disabled. Those individuals who are found to be still disabled are informed by letter that their eligibility has been reviewed and their benefits will continue. Those who are found to be no longer disabled are given notice of this finding, and 10 days in which to advise the DDS that they disagree and plan to submit additional evidence. The agency actually provides another 5 days to recognize mailing time, thereby delaying the termination for 15 days after the date the notice is sent. The beneficiary has 10 more days to present the additional evidence, thereby providing up to a total of 25 days between the time the original notice of intent to terminate is mailed and the date the termination of benefits is processed.

If, after evaluating any additional evidence, the DDS still finds that the beneficiary does not meet the definition of disability in the law, the beneficiary is notified of this finding and is informed that he may appeal the decision by requesting a reconsideration within 60 days of the notice of termination. Under present law, benefits are payable for the month the beneficiary recovers, or in other

words, the month in which the disability ceases (which may be earlier than the month of review), and for 2 additional months. However, under a procedure recently adopted by the Administration, which applies in cases of medical determinations, benefits are now being paid for the month in which the reviewed beneficiary receives notification that he no longer meets the eligibility requirements (the month of cessation), and for 2 additional months. As such, even if medical recovery has been determined to have occurred earlier, the beneficiary is not being held accountable for overpayments prior to the time of review and notification.

IX. EVOLUTION OF LEGISLATIVE AND REGULATORY CHANGES IN THE DEFINITION OF DISABILITY

A. The Legislative Definition

In considering the reasons for the growth of the DI program during the 1960s and 1970s, many analysts have looked to the criteria for determining disability, and in particular the definition of disability in the Social Security Act. Few conclusions can be drawn from such an analysis, however, since the definition in the law has changed relatively little since 1967. It was liberalized a number of times in the early years of the program, and it was actually tightened somewhat with the 1967 amendments. Chart 13 below summarizes the history of the major legislative changes in the DI program relating to eligibility requirements.

Under the original legislation of 1956, to be eligible for DI, the impairment had to be severe enough to prevent the individual from engaging in any substantial employment and to be of "long-continued and indefinite duration." In 1965, the definition was changed to permit benefits for disabilities expected to last at least 12 months.

As the program grew, the Congress began expressing considerable concern over the increased allocations to the DI trust fund required to meet actuarial deficiencies. The Finance Committee, in its report on the 1967 Social Security Amendments, commented:

> The committee recognizes and shares the concern expressed by the Committee on Ways and Means regarding the way this disability definition has been interpreted by the courts and the effects their interpretations have had and might have in the future on the administration of the disability program by the Social Security Administration. * * * The studies of the Committee on Ways and Means indicate that over the past few years the rising cost of the disability insurance program is related, along with other factors, to the way in which the definition of disability has been interpreted. The committee therefore includes in its bill more precise guidelines that are to be used in determining the degree of disability which must exist in order to qualify for disability insurance benefits.

CHART 13

HISTORY OF SIGNIFICANT PROVISIONS RELATING TO DI ELIGIBILITY REQUIREMENTS

Act	Provision
1956	Monthly cash benefits provided for insured workers aged 50-64 unable to engage in substantial gainful activity because of a medically determined impairment expected to end in death or be of "long-continued and indefinite duration."
	Benefits payable after 6-month waiting period.
	Recent and substantial attachment to covered employment required: "currently insured" (6 quarters of coverage in the preceding 13 quarters, including the quarter of disablement), "disability insured" (20 quarters of coverage in the preceding 40 quarters, including the quarter of disablement), and "fully insured" (one quarter of coverage for each year after 1950 and prior to the attainment of age 65 for men, age 62 for women).
1958	Monthly cash benefits provided for the dependents of disabled workers.
	"Currently insured" requirement eliminated.
1960	Age 50 limitation eliminated. DI benefits made payable to insured workers (and their dependents) at any age under 65.
	"Disability insured" requirement eased.
	6-month waiting period eliminated for workers applying for benefits for a second time after failing in attempt to return to work.
	"Trial work period" of 9 months provided during which disabled worker may have earnings without having benefits terminated.

1965	Duration of disability requirement eased from "long-continued and indefinite" to one lasting for at least 12 months.
	In the case of blind workers, aged 55-64, benefits made payable on the basis of inability to engage in usual occupation rather than inability to engage in substantial gainful activity.
	"Disability insured" requirements eased for blind workers under age 31.
1967	Definition of disability tightened so that the impairment must preclude engaging in any substantial gainful activity existing in the national economy.
	"Disability insured" requirements eased for all disabled workers under age 31.
1972	Waiting period reduced to 5 months.
	Medicare provided for disabled workers on the rolls for at least 24 months.
	For blind workers, "disability insured" requirement eliminated.
1977	SGA guidelines liberalized for the blind.
1980	Medicare provided for disabled workers for 3 years after leaving the benefit rolls to engage in substantial gainful activity.
	24-month waiting period for Medicare eliminated for workers applying for benefits for a second time.

The 1967 amendments were intended to emphasize the role of medical factors in the determination of disability. The new language specified that an individual could be determined to be disabled only if his impairments were of such severity that he "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work."

The manner in which the legal definition has been administered—through SSA's rulings, regulations and guidelines—has undergone numerous changes over the years. Whether there has been a consistent pattern toward loosening the disability criteria or toward tightening them is difficult to ascertain. Generally, such changes have not been deliberately intended to do either, but merely to elaborate on the law. Furthermore, changes in the "adjudicative climate" (the pressures felt by disability decision-makers) interact with changes in the formal guidelines and policies of the agency, making it even more difficult to identify changes in the disability criteria that have resulted in a changing basis for disability.

B. Substantial Gainful Activity Criteria

The term "substantial gainful activity" is not defined in the statute. Rather, the Secretary of Health and Human Services is required to prescribe by regulations the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. These criteria have been expressed in regulations in the form of dollar amounts of earnings above which an individual would be presumed to be engaged in substantial gainful activity, and therefore not disabled for purposes of social security.

Originally, work activity was evaluated on the basis of the energies, responsibilities, skills, hours, earnings, regularity and related factors pertaining to the work. This method did not prove to be satisfactory because it frequently resulted in a lack of uniform and repeatable decisions. Thus, consideration was given to more quantitative measures. It was decided that of several options, earnings were the most objective and feasible measure.

In 1958, earnings became the principal measure of SGA. The amount of earnings selected to separate substantial from insubstantial work was $100 a month (with certain exceptions). Annual earnings of more than $1,200 a year were considered inconsistent with the law's tight concept of disability. In addition, earnings of $50 a month or less were considered prima facie evidence of insubstantial work. Where earnings fell between the "upper" and "lower" levels, an individual's ability to engage in SGA was based upon consideration of all pertinent factors including the nature of the activities performed, time spent on the job, and the duration of the work.

The monthly SGA guidelines have since been increased to $125 in 1966, $140 in 1968, $200 in 1974, $230 in 1976, $240 in 1977, $260 in 1978, $280 in 1979, and $300 in 1980. The SGA level remains at $300 today. SGA is higher for blind people ($500 in 1982).

C. Medical Criteria For Determining Disability

Since the enactment of DI, SSA has operated with a list of medical impairments (sets of signs, symptoms and laboratory findings) which, if present in a person applying for benefits and not actually working, are sufficient to justify a finding of disability (without further consideration of ability to work). These criteria are known as the "medical listing of impairments," and are specified in Federal regulations.

The listing includes medical conditions frequently found in people who file for disability benefits. It describes, for each of the 13 major body systems, impairments that are severe enough to prevent a person from engaging in substantial gainful activity and which may be expected to result in death or which have lasted or can be expected to last for a continuous period of not less than 12 months. Table 28 below indicates the general nature of the body systems which are covered by the medical listings.

In determining the severity of an individual's impairment—whether for a new applicant or for a current beneficiary—the medical listings in effect at the time of determination are applied. That is, individuals are found to be either able or unable to engage

in substantial gainful activity by reason of a medically determined mental or physical impairment based on current medical practice and experience and current diagnostic techniques. This procedure ensures that people with identical disabilities are treated comparably as between those who are already on the rolls and those who are first applying for benefits.

With the exception of several years during the early 1970s, this has been the procedure followed throughout the history of the DI program. From 1969 to 1976, social security examiners and administrative law judges operated under a policy whereby termination decisions had to be based on evidence of medical improvement, not simply evidence that the individual failed to meet current eligibility requirements. Referred to as the "LaBonte principle" (named after an administrative law judge's hearing decision), the policy created a situation in which even if SSA learned through medical reexamination that a person had been erroneously awarded DI benefits and was never disabled under the meaning of the law, the individual was allowed to remain on the rolls because there was no evidence of improvement. No similar policy had been in effect prior to 1969 or since 1976. GAO criticized this policy in its report of March 1981. (See Sections V and VI of this print for further discussion.)

The medical listing of impairments was last updated by regulations effective in March 1979, having not previously been updated since 1968. The earlier listings had been criticized by the General Accounting Office (in 1976 and 1978) and others for a lack of specificity, and a failure to take into consideration advances in medical technology. The GAO also commented that State agency officials complained that the listings were sometimes too time consuming or costly to implement. For example, certain criteria required laboratory tests which were no longer commonly used in the medical community or which required equipment which was not readily available.

The Social Security Administration spent several years updating the medical listing. In publishing the new listing in 1979, SSA maintained that the revisions reflected advances in the medical treatment of some conditions and in the methods of evaluating certain impairments. (The medical listing remained essentially unchanged in the August 20, 1980 recodification of the rules for determining disability in DI and SSI.)

TABLE 28.—DI WORKER AWARDS BY CAUSE OF DISABILITY (1976 AWARDS)

	Age			
	Total	Under 35	35–49	50 and over
Total number	565,138	67,408	123,927	373,803
Total percent	100.0	100.0	100.0	100.0
Infective and parasitic	1.0	1.3	1.3	.8
Neoplasms	9.5	5.8	8.5	10.5
Endocrine, nutritional, and metabolic	3.4	3.1	3 3	3.4

TABLE 28.—DI WORKER AWARDS BY CAUSE OF DISABILITY (1976 AWARDS)—Continued

	Age			
	Total	Under 35	35–49	50 and over
Blood and blood-forming organs	.2	.4	.2	.2
Mental disorders	10.2	28.2	12.8	6.0
Nervous system and sense organs	5.9	10.1	6.5	4.9
Circulatory system	26.8	7.3	22.3	31.8
Respiratory system	5.7	1.6	4.1	6.9
Digestive system	2.4	1.8	3.0	2.4
Genitourinary system	.8	1.1	1.0	.6
Skin and subcutaneous tissue	.4	.6	.5	.3
Musculoskeletal system	16.7	12.6	17.8	17.1
Cogenital anomalies	.9	2.2	1.2	.6
Accidents	4.8	12.0	5.2	3.3
Other	.1	.1	.1	.1
Unknown	11.3	11.8	12.1	10.9

Source: Social Security Bulletin, Annual Statistical Supplement, 1980.

Recently, on May 6, 1982, HHS published proposed rules to further revise the medical listings. Like the 1979 revision, this revision reflect advances in the diagnosis and treatment of medical conditions. According to the preamble to the proposed regulations, they are "of a technical-medical nature and no significant change in disability allowance and denial rates is expected". In most instances, the proposed changes are intended to make the regulatory language more specific. While updating the medical listings to take account of medical advances is likely to make only a slight difference in overall allowance rates, individual changes will make it somewhat easier in some cases and somewhat more difficult in other cases for persons with certain impairments to be found disabled. For example, because certain malignant lung cancers have not responded as well to treatment as had been expected, the proposed medical listings would include as disabling impairments cases where the spread of certain cancer cells within the body is less extensive than was required to show disability under existing regulations. This change would update the regulations to take account of actual recent treatment experience and would have the immediate effect of increasing the number of persons found eligible for disability benefits.

Another proposed change, by contrast, would have the immediate effect of reducing the number of individuals found to be disabled because they suffer from mycotic lung infection. Because of improvements in the treatment of this disease, evidence of continuing infection generally would not suffice to establish a disabling condition under the new rules, since the disease is no longer expected to last for 12 months. The new listings would provide criteria for evaluating the permanent lung damage caused by the disease after the acute infection had ceased.

Other proposed changes would make more specific the kinds of findings that would be required to substantiate a determination of disability if treadmill tests were used to document the severity of respiratory disorders or if sound wave (Doppler) tests were used to measure the constriction of blood flow in the blood vessels of the leg. Many of these proposed changes are sufficiently technical that it is difficult even for experts to predict whether they would have any effect on the number of individuals found to be disabled. Their major purpose is to improve the accuracy and uniformity of disability determinations.

D. Vocational Factors Considered in Determining Disability

If the "disability" of an individual cannot be definitely ascertained on the basis of the substantial gainful activity criteria or on the basis of the medical listings, then vocational factors—age, education, and work experience—must also be taken into consideration in determining whether the individual can engage in some other substantial gainful activity which exists in the national economy. Such individuals are not evaluated against an explicit set of uniform classifications where eligibility depends on how they fall within stated impairment classifications. Instead, the requirement that non-medical factors be considered requires that DI decisions be "individualized." It is this part of the disability decision that is thought to require a considerable amount of subjective judgment on the part of the disability examiner and administrative law judge.

Vocational factors, as a consideration in the disability determination process, were first explicitly recognized in the statute in 1967 in a set of amendments intended to emphasize the role of medical factors in the determination of disability. Since the beginning of the program, the Social Security Administration had been operating under guidelines that allowed consideration of vocational factors. However, these were being interpreted in varying ways, and there was believed to be a need to write into law additional language which would define vocational factors in such a way that they could be interpreted and applied on a more uniform basis. The 1967 language specified that an individual could be determined to be disabled only if his impairments were of such severity that he "is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work."

The Report of the Finance Committee on the 1967 amendments discussed this provision further:

> The original provision was designed to provide disability insurance benefits to workers who are so severely disabled that they are unable to engage in any substantial gainful activity. The bill would provide that such an individual would be disabled only if it is shown that he has a severe medically determinable physical or mental impairment or

> impairments; that if, despite his impairment or impairments, an individual still can do his previous work, he is not under a disability and that if considering the severity of his impairment together with his age, education, and experience, he has the ability to engage in some other type of substantial gainful work that exists in the national economy even though he can no longer do his previous work, he also is not under a disability regardless of whether or not such work exists in the general area in which he lives or whether he would be hired to do such work. It is not intended, however, that a type of job which exists only in very limited numbers or in relatively few geographic locations would be considered as existing in the national economy. While such factors as whether the work he could do exists in his local area, or whether there are job openings, or whether he would or would not actually be hired may be pertinent in relation to other forms of protection, they may not be used as a basis for finding an individual to be disabled under this definition. It is, and has been, the intent of the statute to provide a definition of disability which can be applied with uniformity and consistency throughout the Nation, without regard to where a particular individual may reside, to local hiring practices or employer preferences or to the state of the local or national economy.

The application of vocational factors was governed by administrative guidelines until 1979, at which time specific rules were incorporated into the Federal regulations.

A Ways and Means Committee staff report in 1976 urged SSA to clarify the definition of disability so as to remove as much subjectivity as possible in the determination process. The report asserted that the lack of explicit guidance to the disability examiners and administrative law judges on the vocational aspects of the definition, in the form of regulations or the like, had left to the courts the development of how such factors should be weighed. The result, it was argued, was a lack of uniformity in applying decision-making standards, which may have contributed to the adverse financial condition of the DI program.

The implication was that Congress had not expected non-medical factors to play such a central role in the disability decision. Whereas in 1960, SSA reported that as little as 10 percent of all DI allowances were based on vocational factors, it was reported that in 1975 these factors accounted for more than 26 percent of all allowances. According to the staff report:

> Although the 1967 legislation re-emphasized the medical factors as of predominant importance, experience over recent years shows that more and more cases are being determined on the non-medical factors which are those which are the most subjective.
>
> Also, a large percentage of the disallowances involve evaluation of non-medical vocational factors so that in all,

> 45 percent of all substantive determinations involve such factors, and this type of case represents a high percentage of those cases on appeal.

In 1976, the GAO submitted a report to the Ways and Means Committee on the disability determination process, in which they highlighted several weaknesses in SSA's management of the process which could be adversely affecting the uniformity of the decisions being made.[13] GAO based its findings on a sample of cases sent to State agencies for decisions; there was wide variation in the disposition of the sample claims. Where some approved a claim, others denied it; still others indicated there was insufficient documentation to render a decision. The percentage of approval by the States ranged from 47 to 31, and the percentage of denials ranged from 41 to 19. There was complete agreement among the States on only 48 claims (22 percent).

In regard to vocational factors, GAO reported that the effect of inadequate guidance provided to the State agencies had been to create a substantial lack of uniformity in disability decisions. The following excerpt is taken from their report:

> SSA has not provided the State agencies with adequate criteria for considering the weight these factors should play in the adjudication process. As a result, all 10 States had to develop their own vocational guidelines. In our opinion, this provides little assurance of uniformity among the States. Consideration of these factors could vary greatly between adjudicators and result in inequities to claimants. Officials from 9 States said that there was too much room for individual judgment and personal interpretation in applying vocational factors in the adjudication process.

What was occurring in the DI program was a systematic increase in the proportion of benefits awarded on the basis of non-medical and, therefore, less objective criteria. (See Tables 29 and 30.)

In the face of a growing number of non-medical allowances and a declining number of cases where the medical listings were met, the Social Security Administration in 1976 developed a vocational "grid" designed to reduce the subjectivity and lack of uniformity in applying the vocational factors. The grid regulations were designed to explicitly relate certain worker characteristics such as age, education, and past work experience, to the individual's residual functional capacity (RFC) to perform work-related physical and mental activities. If the claimant has a particular level of residual work capability—characterized by the terms Sedentary, Light, Medium, Heavy and Very Heavy—an automatic finding of "disabled" or "not disabled" is now required when applied to various combinations of age, education, and work experience. The regulations were finally promulgated in February 1979, after lengthy administrative hearings and consideration, and remain in effect today.

In writing the regulations, there was no intent to substantively change the program, and thus the regulations were not considered by SSA as liberalizations or deliberalizations of the program. They

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[13] General Accounting Office, *Report to the Congress: The SSA Should Provide More Management and Leadership in Determining Who is Eligible for Disability Benefits*, HRD-76-105, 1976.

were merely intended to put in rule form, guidelines by which disability examiners and administrative law judges throughout the country could make comparable decisions in comparable cases.

E. The Changing Basis of Disability Allowances

As illustrated in Chart 14 and Tables 29 and 30 below, the proportion of disability allowances that involved consideration of vocational factors increased from 16 percent in 1965 to a high of 27 percent in 1975. More recently, however, the basis for disability allowances as between medical and vocational factors has undergone change. Since 1975, the proportion of allowances involving vocational factors has fallen to 22 percent. This is consistent with a generally perceived trend in recent years toward greater reliance on medical evidence in determining allowances and denials.

There has also been a systematic increase in the proportion of allowances that are made on the basis of impairments that "meet" as opposed to simply "equalling" the medical listings. Since 1975, the proportion of allowances based on impairments that meet the listings more than doubled, from 29 percent to 67 percent.

Finally, there has been a significant increase in denials based on "slight impairment"—up from 8 percent in 1975 to 44 percent in 1980. In fiscal year 1980, 21 percent of the DI denials at the State agency level were on the basis of inadequate duration of impairment, 44 percent were on the basis of lack of severity ("slight impairment"), 20 percent were on the basis of ability to perform usual work, and 12 percent were on the basis of ability to perform other work. The increased proportion of denials based on slight impairment appears to have resulted from SSA's efforts to give States more detailed guidance in determining whether an individual has a "severe impairment," and whether his case should be denied without further analysis because his impairment does not meet the required degree of severity—i.e., is a "slight impairment." The States now have available to them lists of impairments which, when occurring alone or in combination with other impairments, are automatically considered slight.

CHART 14

BASIS FOR DISABILITY ALLOWANCES, FISCAL YEARS 1965, 1970, 1973-81

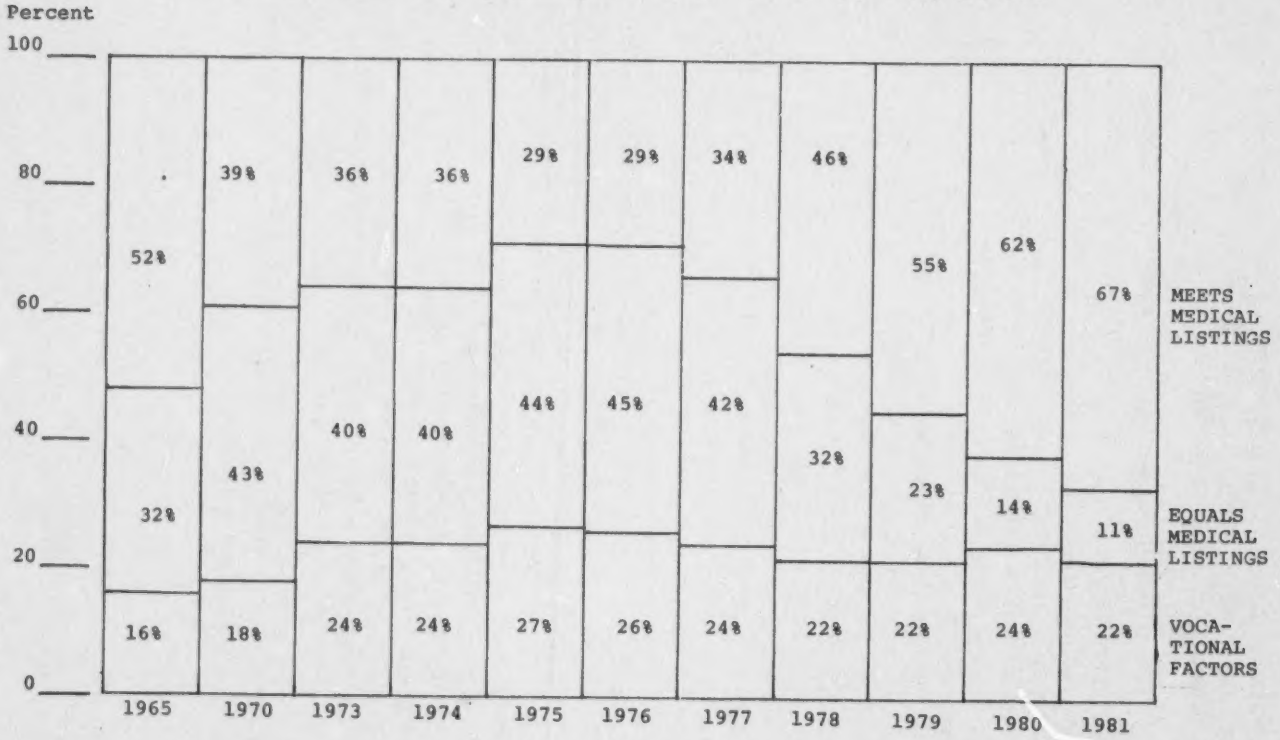

TABLE 29.—BASIS FOR INITIAL DI ALLOWANCES, FISCAL YEARS 1975–81

[In percent]

Fiscal year	Meets listing	Equals listing	Medical and vocational considerations
1975	29.4	43.9	26.7
1976	29.0	45.1	25.9
1977	34.2	41.9	23.9
1978	45.6	31.9	22.5
1979	55.1	22.7	22.1
1980	61.7	14.2	24.1
1981	66.7	11.0	22.2

Source: Ways and Means Committee Print, 97–3, March 16, 1981, as updated by the Office of Research and Statistics of SSA.

TABLE 30.—BASIS FOR INITIAL DI DENIALS, FISCAL YEARS 1975–80

[In percent]

Fiscal Year	Failure to meet 12-mo. duration	Slight impairment	Able to perform usual work	Able to perform other work	Engaging in SGA	Failure to cooperate	Failure to appear	All other
1975	19.6	8.4	44.3	18.2	1.0	5.1	1.8	1.6
1976	19.9	10.8	41.9	20.1	0.4	4.8	1.8	0.3
1977	21.2	24.8	30.0	15.7	0.5	4.9	1.8	1.1
1978	21.1	31.8	25.0	14.6	0.5	4.1	1.9	1.0
1979	20.0	41.6	21.5	12.5	0.4	0.9	2.3	0.8
1980 [1]	20.6	39.0	23.7	12.7	0	1.9	1.3	0.7
1981	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)

[1] Based on a national sample of 16,005 initial denials during fiscal year 1980 done in SSA's central office.
[2] Not yet available.

Source: Ways and Means Committee Print, 97–3, March 16, 1981.

X. PENDING LEGISLATION

A. General Description

Several bills amending the DI program are currently pending before the Congress. In the House, the Ways and Means Committee has reported out H.R. 6181, the Disability Amendments of 1982. The bill would make a number of changes in the program primarily aimed at easing the transition into the periodic review of continuing disability mandated by the 1980 disability amendments. In the Senate, 9 bills dealing with the DI program have been introduced, each of which are described below.

Although estimates of the financial effects of some of these bills have been developed, they have not been done on the basis of a single set of underlying assumptions. Consequently, comparisons of the cost of the various measures are not possible. The expected savings from the new periodic review of the disability rolls range from $.4 billion in fiscal year 1982 to $1.4 billion by fiscal year 1986, however, suggesting that the estimated cost of some of these provisions (those that slow or discontinue the review, for example) may be significant. The committee has recently requested cost estimates on many of the bills that have been introduced.

H.R. 6181, Disability Amendments of 1982

The report of the House Ways and Means Committee on H.R. 6181, expressed the committee's view that even after the enactment of the Disability Amendments of 1980, further legislation is needed, particularly with respect to the termination of benefits resulting from the ongoing review of the benefit rolls and the lack of uniformity in disability decision-making. On May 26, 1982 the committee reported out provisions to modify the CDI process, strengthen the reconsideration stage of appeal, and increase the uniformity of decisionmaking.

Provisions to modify the continuing disability review process

H.R. 6181 contains a number of provisions designed to assist DI and SSI beneficiaries whose disability benefits are terminated. Additional benefits and employment-related services would be provided—beyond the point at which the disabling condition is determined to have ceased—to ease the adjustment off the benefit rolls. These provisions would:

(1) permit a terminated DI beneficiary to elect to have DI and Medicare benefits continue until a reconsideration determination is made but no longer than six months (repayment of DI benefits would be required if the termination decision was upheld);

(2) provide, through calendar year 1984, four additional months of benefits ("adjustment benefits") to individuals who have been on the DI rolls for at least 36 months prior to termination (although not in cases involving substantial gainful activity, fraud, or termination for reasons other than medical cessation);

(3) in cases of medical recovery, not count as overpayments, through calendar year 1984, benefits paid to DI and disabled SSI beneficiaries for months prior to the month in which the notice of benefit termination is received;* and

(4) establish a temporary program in fiscal years 1983 and 1984, funded by the social security trust fund and administered by the Rehabilitation Services Administration, to provide evaluation and job placement services to DI (not SSI) beneficiaries terminated from the rolls because of medical recovery.

Three of these provisions are temporary on the grounds that some adjustments and allowances are in order during the next few years while the existing beneficiary rolls are first being reviewed and until the periodic review procedure becomes a "regular and well-functioning part of the administrative process."

Provisions to strengthen the reconsideration process

One provision in the Ways and Means Committee bill would prohibit the submission of new evidence after the reconsideration decision unless the ALJ decides that such evidence could not have been made available earlier. This partial closing of the record would be applicable only in termination cases where there had been an opportunity for a face-to-face evidentiary hearing as part of the reconsideration process. Such a hearing would be required for all DI and SSI disability termination cases beginning January 1, 1984. An individual who wished to introduce evidence after the reconsideration decision, which could have been made available sooner, would have the option of having the case remanded to the State agency for incorporation of the new evidence or of going directly to an ALJ hearing without the additional evidence. Evidence of a new impairment or of a worsening impairment would continue to be admissible up to the ALJ level under the provisions of H.R. 6181.

By requiring that all available pertinent evidence be presented at the reconsideration, and by requiring a face-to-face hearing with the claimant at the reconsideration stage, the bill is intended to produce better decisions earlier in the process and reduce the number of routine or straightforward cases heard before the ALJ's. In response to concerns raised in committee, the final Ways and Means Committee bill specifies that face-to-face hearings must be "reasonably accessible" to claimants and that States unable to provide such hearings must notify SSA by January 1, 1983 so that SSA can arrange to conduct the hearings. In addition, terminated beneficiaries would have to be notified about the change of rules with respect to the submission of new evidence and encouraged to seek representation by an attorney.

*The Administration is currently operating under this procedure in medical determination cases.

H.R. 6181 also states that the face-to-face hearings, if conducted by the State, must be conducted by an adjudicatory unit of the State agency other than that which made the original decision to terminate benefits. (This separation is already a part of current procedures.) Denied DI or SSI claimants or terminated beneficiaries would have 180 days (rather than 60 days) during which to file a request for a reconsideration of his case.

Provisions to improve the uniformity of decision-making

According to the committee report, one of the Ways and Means Committee's major concerns about the disability determination process is the lack of uniformity in decisions made at the various adjudicative levels, particularly between those made by the State agencies and the ALJ's. The report indicates that the committee believes a large factor in the high rate of reversal of State agency decisions by ALJ's is the fact that State agencies are required to make decisions based on the Program Operating Manual System (POMS)—which is the detailed set of administrative instructions that amplify law, regulations, and rulings—while the ALJ's are bound only by the law, regulations, and rulings. The committee bill therefore includes a provision requiring the Secretary of HHS to "assure that uniform standards will be used in making disability determinations at all levels of adjudication."

Also to improve the uniformity of decisions, H.R. 6181 would require SSA to step up its program of own-motion review. The Appeals Council in SSA's Office of Hearings and Appeals would have to review at least 15 percent of ALJ allowances in fiscal year 1982 and 25 percent in each fiscal year 1983–87. Further, the requirement of Federal review of State agency decisions prior to notification of the claimant or payment of benefits (the "pre-effectuation review" mandated by the 1980 amendments) would be modified. Rather than reviewing 65 percent of allowances in fiscal year 1983 and later, SSA would be required to review 10 percent of *all* State agency decisions (allowances plus denials) in fiscal years 1983 through 1987, with at least one-sixth of the reviewed cases being denials. (This would be a substantial reduction in the level of review required.) If fully implemented, this change would increase program costs. Finally, a statutory clarification of the standards for evaluating pain would be provided.

Miscellaneous provisions

Other provisions approved by the Ways and Means Committee as part of H.R. 6181 would:

(1) automatically revise, based on increases in average earnings levels, the SGA dollar guidelines (and what constitutes a month of trial work for a person who returns to work despite an impairment);

(2) make clear that DI benefits may not be paid until a final determination is made on an application for benefits (to prevent courts from ordering SSA to make interim payments when SSA's processing time exceeds some arbitrary limit);

(3) correct certain unintended effects of the public disability benefit offset enacted last year as part of the Omnibus Reconciliation Act of 1981; and

(4) expand the definition of reimbursable State agency costs for vocational rehabilitation services provided to DI and SSI disabled beneficiaries. Under this provision, States could be reimbursed for services to any beneficiary who recovers from a disabling physical or mental impairment as the result of participation in VR (whether or not he succeeds in nine months of substantial gainful activity and whether or not he was scheduled for a medical re-examination).

TABLE 31.—ESTIMATED AMOUNTS OF ADDITIONAL OASDI BENEFIT PAYMENTS AND VOCATIONAL REHABILITATION PAYMENTS WHICH WOULD RESULT FROM H.R. 6181, AS REPORTED BY THE WAYS AND MEANS COMMITTEE, FISCAL YEARS 1983–87

[In millions]

	Effective	1983	1984	1985	1986	1987	Total 1983–87
Continue payment of DI benefits during appeal through reconsideration.[1]	January 1983	$10	$5	$5	$5	$5	$30
Adjustment benefits	1983–84	15	40	25			80
Waive certain DI overpayments.[2]							
Closing of the record	January 1983	(3)	(3)	(3)	(3)	(3)	(3)
Review of Decisions:							
(a) Review ALJ reversals (own motion review).	Fiscal year 1983 [4]	−5	−15	−20	−30	−35	−105
(b) Review at least 10 percent of State agency determinations[5].	Fiscal year 1983						
Standards for disability determinations.	January 1983	(6)	(6)	(6)	(6)	(6)	(6)
Evaluation of pain	do	(6)	−1	−1	−3	−4	−9
Index the substantial gainful activity amount and the trial work period trigger amount to the retirement test exempt amount for beneficiaries under age 65.	do						
Prohibition against interim payments.	do	(6)	(6)	(6)	(6)	(6)	(6)
(a) Extend worker's compensation offset.	do	−2	−5	−10	−10	−10	−37
(b) Close age 65 "loophole".	do	(6)	(6)	−1	−2	−4	−7

TABLE 31.—ESTIMATED AMOUNTS OF ADDITIONAL OASDI BENEFIT PAYMENTS AND VOCATIONAL REHABILITATION PAYMENTS WHICH WOULD RESULT FROM H.R. 6181, AS REPORTED BY THE WAYS AND MEANS COMMITTEE, FISCAL YEARS 1983–87—Continued

[In millions]

	Effective	1983	1984	1985	1986	1987	Total 1983–87
(c) Worker's compensation offset technical change.	September 1981						
(d) Revise computation of ACE.	January 1983	2	10	15	25	35	87
Payments for vocational rehabilitation services.	October 1982	25	25	10	10	10	80
Total [7]		45	60	25	−5	−5	120

[1] Recovery rate on overpayments is assumed to be 50 percent.

[2] There is no cost associated with H.R. 6181 for this provision because SSA has already decided to stop making retroactive terminations in medical recovery cases. This decision, however, will lead to an increase in DI expenditures.

[3] Preliminary estimate: cost or savings less that $500,000.

[4] It is assumed that enactment of H.R. 6181 will occur too late for SSA to implement the 15-percent review required in fiscal year 1982. Therefore, the estimates do not include the effect of any review of ALJ reversals in fiscal year 1982.

[5] Estimates are based on the assumption that the Administration's present plans for reviewing State agency determinations would remain unchanged. These plans exceed the minimum requirements of section 6(b) of the bill. If the Administration's present plans were changed to meet only the minimum requirements of the bill, total benefit payments during the 5-year period 1983–87 would be increased by an estimated $145 million.

[6] Reduction in benefit payments is estimated to be less than $500,000.

[7] Amounts shown represent net effect of all sections after interaction. Figures for the individual sections do not include the effect of interaction with the other proposals.

Note: The estimates are based on the assumptions in the 1982 Trustees' Report, alternative II–B.

Source: Office of the Actuary, SSA; June 30, 1982.

S. 1944, Introduced by Senator Levin, et al.

Introduced on December 11, 1981, prior to the development of a more far-reaching bill (S. 2674), Senator Levin's bill would simply provide that terminated DI beneficiaries may continue to receive DI and Medicare benefits until all administrative appeals have been exhausted (through the Appeals Council decision). However, benefits could be terminated sooner if the Secretary could produce current medical evidence indicating an improvement in the individual's disabling condition. S. 1944 would not require repayment of benefits paid beyond the initial termination decision, even if the termination was upheld on appeal.

S. 2086, Introduced by Senator Metzenbaum, et al.

Introduced on February 9, 1982, S. 2086 would permit the continuation of DI and Medicare benefits during the appeal period (through the ALJ decision), but only if: (1) there is a "substantial difference of medical opinion" as to the severity of the individual's disabling condition; or (2) the beneficiary is "substantially dependent" on DI benefits for support. The benefits paid beyond the initial termination would be subject to repayment, except that no beneficiary whose monthly income for the month following the month of termination was less than 150 percent of the poverty line could be asked to repay. The bill would also add to the statutory language governing continuing disability reviews an explicit requirement that SSA or the State agency seek current medical evidence from the beneficiary's treating physician or other medical provider (as noted in Section VIII C, this is currently operating policy). SSA would be required to allow at least 30 days for the beneficiary to submit medical evidence after he had been notified of the impending review (as compared to the 10 days authorized under present administrative practice).

S. 2659, Introduced by Senators Sasser and Burdick

S. 2659, introduced on June 22, 1982, would permit the continuation of DI benefits through the reconsideration decision in termination cases, and Medicare eligibility through the ALJ decision. Benefits would not continue, however, if the individual was engaging in substantial gainful activity. S. 2659 does not require repayment of these additional benefits.

The bill would also make a broader change in the disability adjudication process. Denied claimants and terminated beneficiaries would be given the opportunity for a face-to-face evidentiary hearing—prior to the ALJ hearing—as part of the reconsideration of their case at the State agency level. Finally, the bill would require the Secretary of Health and Human Services to make a quarterly report to the Congress on the CDI process (including the numbers and rates of termination and the disposition of appeals).

S. 2674, Introduced by Senator Levin, et al.

Introduced on June 24, 1982, S. 2674 was described as "comprehensive legislation to reform the Social Security Administration's procedures for determining the continued eligibility of individuals who receive disability benefits." S. 2674 contains provisions to alter the CDI process and to change the disability determination process generally.

Provisions to modify the CDI process

First, S. 2674 would prohibit the termination of DI benefits unless the individual has medically improved or shown that he could engage in substantial gainful activity, or unless the original decision entitling him to benefits was the result of fraud or was "clearly erroneous" based on the standards in effect at the time of the original determination. Second, like a number of the other current proposals, the bill would continue DI and Medicare benefits dur-

ing appeal (paid until the month preceding the month of the ALJ decision). If the ALJ upheld the termination decision, payments made during the appeal process would be subject to recoupment as overpayments.

Provisions to alter the disability determination process generally

Rather than attempt to strengthen the reconsideration stage of the process as in H.R. 6181, this bill would strengthen the initial determination of disability by the State agency and eliminate reconsideration altogether for both new DI entitlements and continuing eligibility determinations. Under S. 2674, each claimant or beneficiary would be notified of the State agency's preliminary finding of ineligibility and given an opportunity for a face-to-face interview with State agency personnel before the denial or termination decision became final. Evidence not submitted by the individual at this time would not be admissible later in the appeals process if it could have been made available to the State agency. Persons submitting new pertinent evidence after the State agency decision would be permitted to have their cases remanded to the State agency for further review, or they could proceed directly to an ALJ hearing at which the new evidence would not be considered. Each person who requested a review of his case by the State agency (after the preliminary finding of ineligibility) would have to be informed both orally and in writing of the rules pertaining to submission of evidence and encouraged to consider retaining an attorney or other representative to assist him.

S. 2725, Introduced by Senator Cohen, et al.

In introducing S. 2725 on July 13, 1982, the sponsors argued that an interim bill should be approved to protect severely disabled workers whose benefits are erroneously terminated. S. 2725 has two provisions. The first would continue DI and Medicare benefits through the ALJ decision for terminated beneficiaries pursuing an appeal; DI benefits would be subject to repayment if the termination decision was upheld by an ALJ. The second provision would direct the Secretary of HHS to slow down the continuing eligibility reviews (now required at least once every three years for nonpermanent disabilities). The Secretary would be required to consider whether State agencies had sufficient personnel and processing time to permit high quality reviews. The Secretary would also be required to establish criteria under which priority would be given to cases in which ineligibility was most likely to be found. (As discussed in Section V, this is already part of current operating procedures.)

S. 2730, Introduced by Senator Heinz, et al.

One of two bills introduced by Senator Heinz, et al. on July 14, 1982, S. 2730 is, according to its sponsors, intended to give Congress time to consider changes in the disability adjudication system. S. 2730 would simply stop periodic reviews of the continuing eligibility of DI and SSI beneficiaries until January 1, 1983 except in those cases that are "diaried" (cases in which medical recovery was considered likely at the time of the original disability determina-

tion), involve fraud, or in which the individual has returned to substantial work.

S. 2731, Introduced by Senator Heinz, et al.

Also introduced on July 14, 1982, S. 2731 would make a number of changes in the CDI process and two changes that would also affect initial determinations of eligibility.

Provisions to modify the CDI process

S. 2731 would permit the continuation of DI and Medicare benefits beyond the point at which the disability is determined to have ceased—through the reconsideration decision or, if the claimant was not given an opportunity for a face-to-face evidentiary hearing as part of the reconsideration (which SSA would be required to make available as of January 1, 1984), through the ALJ decision. These benefits would be subject to repayment if the original termination decision was upheld (although Medicare benefits would not be recovered).

Similar to the provision of H.R. 6181, an additional 2 months of "adjustment benefits" could also be paid after the month of cessation of disability for individuals who had been on the rolls for at least 36 months. These benefits would not be subject to recoupment. (This provision would apply with respect to terminations occurring prior to January 1, 1985.) Neither the extended benefits during appeal nor the adjustment benefits could be paid if the beneficiary was engaging in substantial work or if the case involved fraud.

The proposed legislation would also change the rules for continuing eligibility reviews by prohibiting the termination of benefits unless the Secretary finds that there has been "substantial medical improvement" in the beneficiary's impairment(s) or unless there is newly discovered medical evidence that clearly shows the individual's functional capacity to engage in substantial work on a regular and sustained basis. If the original decision to award benefits has been made on appeal (by an ALJ, by the Appeals Council, or in Federal court), the State agency could not terminate benefits unless there was a finding of medical improvement. If the State agency believed the beneficiary to be ineligible despite the lack of evidence of medical improvement, the case could be referred to an ALJ or the Appeals Council for review.

For individuals on the benefit rolls, who were originally awarded benefits some time ago, this bill would alter the periodic review requirements mandated in the Disability Amendments of 1980. Individuals who were on the DI rolls prior to the enactment of the amendments would no longer have to be reviewed at least once every three years. Their cases would be reviewed only at such times as the Secretary of HHS believed would ensure "sufficient personnel and processing time to conduct reviews of the highest quality" and reviews that were "cost-effective."

Other provisions pertaining to continuing disability review procedures would:

(1) require HHS to make "all reasonable efforts" to obtain complete current medical evidence from the beneficiary's treating physician before making a decision to terminate benefits;
(2) require that the date of termination of benefits be no earlier than the date the beneficiary is notified of the decision that he is no longer eligible for benefits[14] (unless the beneficiary has returned to substantial work or has engaged in fraud);
(3) require HHS to make a quarterly report to the Congress on CDI's including the numbers of reviews carried out, the rates of termination, and the disposition of appeals; and
(4) require SSA to assist beneficiaries with mental impairments who need assistance in connection with a continuing disability review.

Provisions to modify the disability determination process

S. 2731 would require the States (or SSA) to give denied claimants and terminated beneficiaries an opportunity for a face-to-face hearing as part of the reconsideration process by January 1, 1984. In addition, the bill would require the Secretary to have uniform standards applied at all levels in the disability determination process. These standards would be subject to the rulemaking procedures established under section 553 of title V, U.S. Code.

Finally, S. 2731 would expand the existing provision for trust fund financed vocational rehabilitation services for disabled social security beneficiaries. In order for the States to be eligible for reimbursement, beneficiaries would no longer have to be able to engage in SGA for nine months; States could be paid for services to beneficiaries whose medical recovery was attributable to VR whether or not they returned to work.

S. 2739, Introduced by Senator Metzenbaum, et al.

Introduced on July 15, 1982, S. 2739 would make several changes dealing with the CDI process as well as a number of changes in the disability determination process. First, DI and Medicare benefits would be payable during the appeal process (through the ALJ decision). These additional benefits would be subject to recoupment if the termination decision was upheld. Second, the termination of DI benefits would be prohibited unless: (a) there was evidence of medical improvement to show that the individual was no longer disabled under the standards in effect at the time of the original determination; or (b) the original disability determination was "clearly erroneous"; or (c) the beneficiary was engaging in substantial gainful activity. Third, SSA or the States would be required to obtain current medical evidence and medical history from the individual's treating physician before deciding to purchase a consultative examination. Finally, SSA and the States would be required to consider as disabling, those impairments not listed in the regulations that are as severe as those listed as well as combinations of impairments that are "equivalent" to those listed. (As discussed in Sections VIII B and E, this is already current operating procedure.)

[14] The Administration is currently operating under this procedure in medical determination cases.

S. 2776, Introduced by Senator Riegle, et al.

Introduced on July 26, 1982, S. 2776 would require SSA to document medical improvement or document that the original decision granting benefits was clearly erroneous in order to terminate disability benefits. The bill would also slow down the CDI process by limiting the number of cases reviewed in any one calendar year to the number of new DI beneficiaries who joined the rolls in the preceding calendar year. Finally, disability benefits would continue to be paid through the ALJ level, subject to recoupment if the hearing decision affirms that the individual is no longer disabled.

APPENDIX A: DISABILITY INSURANCE COSTS AND FINANCING OVER THE YEARS

96-297 O—82——9

With the exception of the experience of the past few years, the DI program has been plagued by a history of underfinancing almost since its inception. Within 5 years after enactment in 1956, the Board of Trustees of the social security program was forecasting that the DI program would not have sufficient resources at some future date to meet fully its benefit obligations. Over the 25-year life of the program, 1957 to 1981, the trustees reported a long-run financing deficiency on 15 separate occasions. As a result, on some six occasions Congress had to take steps to increase the amount of tax revenues going to the program.

TABLE 32.—DI FINANCIAL FORECASTS IN EARLIER TRUSTEES' REPORTS

[Intermediate Assumptions]

Year of earlier trustees' report	Long-range cost [in percent of taxable payroll]	Cost estimates for CY 1980 [dollars in billions]
1957	0.42	$1.0
1960	0.35	1.5
1965	0.63	2.0
1967	0.85	3.2
1972	1.18	NS
1977	3.68	17.4
1980	1.50	[1] 15.9
1982 [1]	1.50	[2] 15.9

[1] Actual for 1980.
[2] Estimate.
NS—Not shown in report.
Source: Congressional Research Service, July 1982.

Under-financing—a phenomenon until the late 1970s: The 1961 and 1962 Board of Trustees of the social security programs reported a long-range actuarial deficiency for DI of 0.06 percent of taxable payroll.* Although slightly beyond the acceptable margin of variation for long-range estimates, this level was considered at that time as being close to actuarial balance. However, in 1962 annual deficits began to appear. Expenditures exceeded revenues by $69 million in that year and rose to a difference of nearly $440 million in 1965. The 1963, 1964 and 1965 reports of the trustees showed a long-range deficit of 0.14 percent of taxable payroll. The 1964 report suggested that the DI Trust Fund would be exhausted by

*In 1982, taxable payroll will amount to $1.361 trillion (under Trustees' intermediate II-B assumptions).

1971. In all three reports the trustees recommended that a higher allocation of the overall tax be given to the DI program.

Congress enacted a higher allocation to DI in 1965. While an annual deficit did not reappear in the program until 1975, the trustees continued to show long-range actuarial shortfalls in the intervening period. For instance, less than two years after the higher allocation had been enacted, the trustees in their report of 1967 showed once again a long-range actuarial deficit of 0.15 percent of taxable payroll. Congress, again in 1967, provided a higher tax allocation to the program.

Up until the 1980 amendments, Congress repeatedly addressed projections of higher costs of the program by increasing its tax allocation. A 1974 report of the staff of the Ways and Means Committee commented on this traditional approach to the financing shortfalls as follows:

> In the past, actuarial deficiencies have been eliminated by increased allocation of payroll tax receipts to the disability insurance system. Higher allocations were effectuated in 1965, 1967, and, to a smaller degree, in the two social security bills which were enacted in 1972. The last such action was taken in Public Law 93-233 which was approved on December 31, 1973. The 1974 trustees' report suggests reallocation of income among the three trust funds (OASI, DI, and HI) as a possible solution to the short-range financing problems of the social security program. The staff recommends that no further action of this nature be taken—which, to some degree, avoids facing the problems in the disability insurance program—until the committee receives an adequate explanation of the adverse experience which is taking place in the system.
>
> The long-range actuarial deficit of nearly 3 percent of payroll in the social security program announced in the trustees' report [1974] is a clear indication that the practice of increasing the allocation of funds to the disability insurance Trust Fund cannot be indulged in in the future as it has been in the past. Prior to 1972 there was a built-in "safety" factor in the "level earnings" assumption that was used in estimating the long-range cost of the social security program. The use of the level earnings assumption generated actuarial surpluses as earnings levels rose and they had been used, among other things, to make up for adverse disability experience. However, under the "dynamic earnings" assumption adopted in 1972 this cushion no longer exists [U.S. Congress, House, Committee on Ways and Means, *Committee Staff Report on the Disability Insurance Program,* 93rd Congress, 2d session, 1974, p. 4.]

The long-range projected deficit for OASI and DI, combined, mentioned in the Ways and Means Committee staff report, grew from 2.98 percent of taxable payroll in the 1974 trustees' report to 8.20 percent of taxable payroll in the 1977 trustees' report. The portion of the deficit attributable to DI in the 1974 report was 0.40 percent of taxable payroll. By 1977 the trustees were projecting a deficit for DI of 2.14 percent of taxable payroll—reflecting an aver-

age revenue shortfall over the 75-year period of almost 60 percent of the cost of the DI program.

While the higher tax allocations to the DI program and the benefit decoupling provisions enacted with the 1977 Social Security Amendments substantially improved the financial outlook for the program, the official estimates at the time of passage still showed a long-range actuarial deficiency for DI of 0.38 percent of taxable payroll. The threat of immediate insolvency was nevertheless removed. An annual deficit of $2.5 billion was projected for calendar year 1977, but annual surpluses beginning in 1978 were projected through the remainder of the century.

The following tables show the DI tax increases enacted in 1977 and estimates, made shortly after enactment, of the financial condition of the DI trust fund prior to and following the enactment of the 1977 amendments.

TABLE 33.—CHANGE MADE TO DI PORTION OF SOCIAL SECURITY TAX RATE BY THE 1977 AMENDMENTS

[Employee-employer rate in percent]

	Old law DI rate	New law DI rate	Percent change
1982–84	.650	.825	+27
1985	.650	.950	+46
1986–89	.650	.950	+36
1990–2010	.700	1.100	+57
2011 and later	.850	1.100	+29

Source: Congressional Research Service, July 1982.

Note: Additional funding for the DI program was also provided by the increases enacted in 1977 in the taxable wage base.

TABLE 34.—ESTIMATED OPERATIONS OF THE DI TRUST FUND PRIOR TO AND AFTER THE 1977 AMENDMENTS

[Dollar amounts in billions]

	Income		Outgo		Net increase in funds		Funds at end of year		Funds at beginning of year as a percentage of outgo during year	
	Prior law	1977 amendments	Prior law	1977 amendments	Prior law	1977 amendments	Prior law	1977 amendments	Prior law	1977 amendments
Calendar year:										
1977	$9.6	$9.6	$12.0	$12.0	−$2.4	−$2.4	$3.3	$3.3	48	48
1978	10.9	13.8	13.6	13.7	−2.8	.2	.5	3.5	24	24
1979 [1]	11.8	15.7	15.3	15.3	−3.5	.4	−3.0	3.9	3	23
1980	12.8	17.6	17.4	17.1	−4.6	.5	−7.6	4.4	([2])	23
1981	14.6	21.1	19.5	19.0	−4.9	2.1	−12.5	6.5	([2])	23
1982	15.5	23.0	21.7	20.9	−6.2	2.1	−18.7	8.6	([2])	31
1983	16.2	24.7	24.1	22.9	−8.0	1.8	−26.6	10.4	([2])	38
1984	16.8	26.5	26.8	25.2	−10.0	1.3	−36.6	11.6	([2])	41
1985	17.3	32.1	29.8	27.7	−12.4	4.5	−49.1	16.1	([2])	42
1986	19.3	34.9	33.0	30.3	−13.6	4.6	−62.7	20.8	([2])	53
1987	20.0	37.4	36.4	33.1	−16.4	4.3	−79.1	25.1	([2])	63

[1] Because it was estimated that the DI trust fund would have been exhausted in 1979 under prior law, the figures for 1979–87 under prior law were purely theoretical.
[2] Fund would have been exhausted in 1979.

Note: The above estimates were based on the intermediate set of assumptions shown in the 1977 Trustees Report.

The 1978 trustees' forecast—cautious reappraisal: The 1978 trustees' report issued just six months after enactment of the 1977 amendments showed a substantial improvement in the long-range financial condition of the DI program. Although still projecting a long-range deficiency, the report showed an actuarial imbalance for DI of only 0.14 percent of taxable payroll. As for the short-range, it showed trust fund reserves rising to a level of 190 percent of outgo in 1987.

The 1978 report stated:

> Large decreases in the estimated cost of the disability insurance program in both the medium-range and long-range were due to changes in assumptions regarding disability incidences and terminations. Both incidence and termination rates have been changed to reflect more recent experience. In addition, lower incidence rates are projected due to the decreased attractiveness of disability benefits, because of the generally lower benefits available under the new decoupled benefit calculation procedure.

The more recent experience referred to showed that DI awards dropped off slightly in 1976 and 1977, from the high of nearly 600,000 awards to disabled-workers in 1975, and that termination rates increased. Nonetheless, recognizing the propensity of past trustees to underestimate the costs of the program, the 1978 trustees' report continued to forecast a substantial upward trend in the size of the program. The report stated:

> Although the disability award rate during 1977 remained level as compared with 1976, a generally upward trend in incidence rates, as experienced over the past decade, was assumed to continue. Age-sex specific incidence rates were assumed to increase over the period 1978–97 to a level about 25 percent higher than that estimated for 1977, and to remain at that level thereafter.

1979 trustees' report—an apparent turning point: The 1979 trustees' report once again showed improvement. For the first time since 1970, the trustees projected a long-range actuarial surplus for DI, amounting to .21 percent of taxable payroll. This represented a reduction of 0.34 percent of taxable payroll relative to the previous year's long-range cost estimates (equivalently, a 15 percent reduction in future cost estimates). As did the 1978 forecast, the 1979 report attributed the improvement in the long-range condition of the program to recent experience more favorable to the program. Awards to disabled workers dropped from a level of about 569,000 in 1977 to 457,000 in 1978.

While forecasting a considerably lower rate of growth, the trustees again were reluctant to project a long-term leveling off of the program. The report stated:

> Although disability awards declined by over 20 percent in 1978, age-sex specific incidence rates were assumed to increase over the period 1979–1998 to about 10 percent higher than the average for 1977–1978, and to remain constant thereafter. This represents a gradual return to 1976–1977 experience.

> . . . This reduction in the incidence of disability was not anticipated and its causes are not very clear, so it is uncertain whether the trend will continue in the future. Thus, the higher DI trust fund levels projected in this report (as compared to last year's report) are contingent on the realization of the lower incidence rates assumed in this year's report.

1980–1982 trustees' report—further improvement: With the allowance rate falling and the number of terminations from the rolls rising, subsequent trustees' reports (in 1980, 1981 and 1982) showed additional short- and long-range improvement in the financial projections of DI. The 1980 report showed a long-range actuarial surplus of 0.64 percent of taxable payroll (three times the surplus shown in the 1979 report). Reserves at the beginning of 1987 were estimated to be equal to 254 percent of outgo. Similar short- and long-range situations were reflected in the reports for 1981 and this year. Under intermediate assumptions, the 1982 trustees' report shows an average 75-year surplus of 0.66 percent of taxable payroll.

APPENDIX B: REPRINTS OF RECENT REPORTS

1. The Bellmon Report

IMPLEMENTATION OF SECTION 304(g)

OF PUBLIC LAW 96-265,

"SOCIAL SECURITY DISABILITY AMENDMENTS OF 1980"

REPORT TO THE CONGRESS

BY THE SECRETARY OF HEALTH AND HUMAN SERVICES

Prepared by Department of Health and Human Services
Social Security Administration
January 1982

Report by the Secretary of Health and Human Services
on Implementation of Section 304(g) of P.L. 96-265,
"Social Security Disability Amendments of 1980"

"THE BELLMON REPORT"

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EXECUTIVE SUMMARY

Section 304(g) of P.L. 96-265, the "Social Security Disability Amendments of 1980," requires that the Social Security Administration (SSA) institute a program of ongoing review of administrative law judge (ALJ) decisions on claims for Social Security disability benefits. This section—commonly referred to as the Bellmon amendment—is intended to ensure that hearings decisions by ALJs conform to statute, regulations, and binding policy. Decisions which do not meet these criteria are to be administratively reversed.

Section 304(g) further requires that the Secretary of Health and Human Services submit to the Congress by January 1982 a report on progress toward implementing the ongoing review. This report has been prepared to fulfill that requirement. As requested by the Conference Committee on P.L. 96-265, it also attempts to identify the effect of certain factors on ALJ decisions.

Initial decisions on applications for disability benefits and reconsiderations of those decisions are made by SSA district offices and State disability determination services (DDSs). Denials may be appealed sequentially to an ALJ, to the Appeals Council in SSA's Office of Hearings and Appeals (OHA), then to Federal district courts. The requirement for this report arose from congressional concern with the increasing number of denials being appealed to ALJs and the high percentage of DDS denials that were being overturned by ALJs.

SSA has now completed an initial review that is the basis of this report and that provided guidance for an ongoing review, which was begun in October 1981.

Findings of the Initial Review

The initial review was based on a sample of 3,600 recent ALJ decisions on disability cases. The case folders were reviewed by two different units within SSA: the Office of Assessment (OA), which operated under the standards governing the DDSs, and the Appeals Council, which applied the standards and procedures governing ALJ decisions. Each unit made new decisions on each case without being aware of the original ALJ decision or the decision of the other reviewing organization. These new decisions were used only for analytical purposes; they were not used to actually alter the original ALJ determination.

The major finding of the initial review was that significant differences in decision results were produced when these different decisionmakers were presented with the same evidence on the same cases. The ALJs allowed 64 percent of the cases. The Appeals Council, applying ALJ standards, allowed 48 percent. OA, applying DDS standards, allowed only 13 percent.

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An examination of the standards and procedures governing the ALJs and DDSs indicates distinct differences. In certain instances, operational definitions are not identical. In other instances, ALJ procedures permit a finding of disability that is not possible under the DDS standards. Finally, in some areas the definitions contained in the standards are the same, but procedures differ for evaluating evidence of impairment.

Initial review data also indicated that, even when decisionmakers were applying the same standards, they were not applying them consistently. The Appeals Council denied 37 percent of the cases which ALJs allowed, and allowed 21 percent of the cases which ALJs denied. A detailed examination of the cases on which both the ALJs and the Appeals Council agreed shows that the Council agreed with the ALJs as to the basis for an allowance or denial much less frequently than it agreed on whether the case should be allowed or denied. Moreover, if the Appeals Council decision is taken as the "correct" decision under the rules governing ALJs, the review indicates that decisions to allow cases by ALJs with high allowance rates are more often "incorrect" than the decisions of ALJs with lower allowance rates.

There are also indications that varying quality control procedures and management emphases, in combination with the subjective element in the disability determination process, may contribute to the distinct differences and trends in disability decisions made at the different organizational levels.

Results from the review suggest that the in-person appearance of claimants at ALJ hearings may make a difference. The ALJ hearing is the first time that the claimant appears before a decisionmaker. As part of the review, all information related to the claimant's in-person appearance was removed from a special subsample of case folders and these folders were then distributed to other ALJs for readjudication based on the case record. The original ALJ allowance rate of more than 60 percent dropped to 46 percent when the in-person information was removed from the case.

Data from this special subsample also show that additional medical evidence submitted after the DDS decision significantly affects ALJ allowance rates. The ALJ allowance rate dropped from 46 percent to 31 percent when all evidence added after the final DDS decision was deleted from folders in the sample.

The Ongoing Review

SSA's ongoing review, implemented in October 1981, will identify ALJ decisions that are inconsistent with SSA policy and standards and revise those decisions as appropriate.

The review is being conducted by the Appeals Council, which has the authority to review all ALJ decisions and dismissal actions at the request of the claimant or on its own motion. The current review sample of about 7½ percent of total ALJ allowances in Disability Insurance cases has been selected from the decisions of ALJs and hearing offices with the highest allowance rates. In addition to enabling SSA to correct

erroneous decisions, this review will provide SSA with the ability to continously monitor the disability adjudication process to ensure that problems identified in the initial review are corrected and that any additional areas of weakness are identified and acted upon.

Later in fiscal year 1982, the ongoing review will be expanded; by the end of the fiscal year, we plan to review 15 percent of ALJ allowance decisions on Disability Insurance claims.

Other Initiatives at the Hearing Level

To address the problem of different adjudicative standards and procedures being used by DDSs and ALJs, the Social Security Administration will disseminate a single set of standards to be followed at all levels of adjudication. These standards will be based on those currently governing the DDSs.

The Office of Hearings and Appeals also has established a special staff in its central office to develop new and more extensive training programs for ALJs and their staffs. Through its training initiatives, OHA expects to promote among ALJs and their support staffs a better understanding and application of both current and revised standards and procedures, resulting in greater consistency and accuracy in decision-making.

OHA is discontinuing the current allowance decision forms used by ALJs. A revised format has been developed to ensure not only that allowance decisions contain specific explanations for the favorable conclusions, but also that they reflect adherence to the process of sequential disability evaluation directed by the regulations.

Further, an experiment will be undertaken later this year to determine whether participation of an SSA representative at ALJ hearings in which the claimant is represented will improve the quality and timeliness of hearing decisions.

Initiatives to Improve DDS Performance

As required by the 1980 Disability Amendments, SSA has begun a preeffectuation review of DDS disability allowances. This preeffectuation review, in which incorrect decisions made by the DDSs are reversed prior to notification of the claimant or payment of any benefits, is intended to promote the uniformity and accuracy of disability allowances made by the DDSs.

SSA is also conducting three experiments that test various changes in the DDS reconsideration process. These changes may result in more consistent decisions when cases move on to ALJ hearings.

In summary, SSA has undertaken a number of activities designed to respond to the problems identified in the initial review. The most significant are probably the ongoing review of ALJ decisions required by P.L. 96-265, and the initiation of changes required to ensure that all SSA disability decisionmakers are governed by the same standards. These actions, in conjunction with the other initiatives discussed in this report, should greatly improve the accuracy and consistency of disability decisions made throughout the SSA adjudicative system.

Introduction

During the past decade, the Social Security Disability Insurance program has come under considerable congressional scrutiny. This decade of review culminated in Public Law 96-265, the "Social Security Disability Amendments of 1980."

The primary purpose of these amendments was to strengthen the integrity of the disability programs by placing a limit on the amount of Disability Insurance benefits in those cases where the benefits tend to exceed the net predisability earnings of the disabled worker, by providing positive incentives (as well as removing disincentives) for disability beneficiaries to return to work, and by improving accountability and uniformity in the administration of the disability programs.

Section 304(g) of the 1980 Amendments required the Secretary of Health and Human Services to review, on his own motion, disability decisions made by administrative law judges (ALJs). This provision—commonly referred to as the Bellmon Amendment—arose out of the congressional concerns about the increasing number of disability decisions being appealed to the hearing level, the high percentage of allowances at that level, and the accuracy and consistency of ALJ decisions. ALJs were allowing a larger proportion of cases than they had in the past, and the backlog of cases awaiting hearing was rapidly increasing.

This report was prepared in response to the congressional requirement to initiate a review of disability decisions at the hearing level and to report on that review. Chapter I presents the details of the congressional mandate. Chapter II provides background information on the disability benefit programs and the process of adjudicating disability claims. Chapter III discusses the findings of the Social Security Administration's initial review of ALJ decisions. Chapter IV discusses the progress in implementing an ongoing review of ALJ decisions. In addition, this final chapter also discusses other initiatives undertaken by the Secretary to improve the quality of disability adjudication at both the hearing and prehearing levels.

I. The Congressional Mandate

Section 304(g) of P.L. 96-265 (the Bellmon Amendment) provides that:

> The Secretary of Health and Human Services shall implement a program of reviewing, on his own motion, decisions rendered by administrative law judges as a result of hearings under section 221(d) of the Social Security Act, and shall report to the Congress by January 1, 1982, on his progress.

The Conference Committee agreed to this provision after striking language which specified what was to be included in the required report. The discussion of this provision contained in the Conference Report, however, states the conferees' belief that the Secretary's report should include the percentage of ALJ decisions being reviewed and should describe the criteria for selecting the decisions to be reviewed. The conferees also indicated that the Secretary's report should identify the effects of five specific factors on ALJ decisions:

(1) Claimants' first appearance in person before a decisionmaker;
(2) Additional evidence submitted at the hearing level;
(3) Significant changes in State agency denial rates;
(4) Differences between State agency (DDS) and ALJ policy guidelines;
(5) Differences in standards applied by ALJs.

To respond to the congressional mandate for a review program and for a report to address the above factors, SSA decided on a dual approach: an initial review designed to collect necessary data and an ongoing review designed to ensure that hearing decisions conform to statute, regulations, and binding policy. The initial review collected information on differences in adjudication between the prehearing and hearing levels and on the degree of uniformity at the hearing level. The information obtained from the initial review was also used to develop an ongoing program of own-motion review, which began October 1, 1981.

II. Background

The Social Security Disability Insurance (DI) program, providing cash benefits to disabled workers age 50 and older, was established by Congress in 1956. Dependents' benefits were added in 1958 and the age-50 requirement was eliminated in 1960.

To qualify for benefits an individual must meet certain insured status requirements. These requirements have been modified over the years, but still require that workers (other than the blind) who are disabled after age 31 must have worked in employment or self-employment covered by Social Security for 5 out of the last 10 years prior to their disability. For workers under age 25 the minimum requirement is 1½ years of work out of the 3 years prior to disability; for workers age 25 through 31, progressively more years of coverage are required. A worker is required to wait 5 full calendar months after the onset of disability before benefits are payable.

The Social Security Amendments of 1972 "federalized" the State public assistance programs for the needy aged, blind, and disabled into the Title XVI Supplemental Security Income (SSI) program. This program pays Federal benefits, under uniform rules, financed from general revenues. Payments under the SSI program, which started in January 1974, may be supplemented by the individual States. Under SSI, disabled or blind persons on the State programs before July 1973 were automatically "grandfathered in" under the States' own definitions of disability. New applicants and applicants who came on the welfare rolls after June 1973 must meet the same definition of disability as applicants under the Disability Insurance program. They are not subject, however, to any waiting period.

A. Definition of Disability

The statutory definition of disability originally required that the worker must be unable "to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or be of long-continued and indefinite duration." In 1965, the statutory language was changed to stipulate a duration requirement of at least 12 months in place of the previous "long-continued and indefinite duration" requirement. Amendments in 1967 further specified that an individual's physical or mental impairment(s) must be ". . . of such severity that he is not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work." (Sections 223 and 1614 of the Social Security Act.)

B. The Disability Decision—A Sequential Evaluation Process

The standards for evaluating disability claims are not further defined in the statute itself, but rather are set forth in SSA regulations (20 C.F.R. parts 404 and 416, subparts P and I, respectively) and written guidelines. The regulations are intended to ensure uniformity and fairness in the disability determination process. They set out a sequence of steps and criteria for determining whether or not an applicant meets the definition of disability in the law.

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The first step in the sequential evaluation is to determine whether the claimant is currently engaged in substantial gainful activity (SGA). The law requires the Secretary of HHS to prescribe, by regulation, the criteria for determining when services or earnings from services demonstrate an individual's ability to engage in SGA. The regulations establish dollar amounts of earnings; earnings above these amounts ordinarily show that an individual is engaged in SGA and therefore is not disabled for purposes of the Social Security definition. This amount is currently $300 a month.

The next step in the sequence is to determine whether the claimant has a "severe" impairment. The regulations define "severe" impairment as one that "significantly limits physical or mental ability to do basic work activities." (Sections 404.1520(c) and 416.920(c).) If the claimant does not have an impairment that is considered severe, the claim is denied on medical considerations alone.

If the claimant does have a severe impairment that meets the duration requirement, the next step is to determine whether the impairment meets or equals the degree of severity in the Medical Listing of Impairments. This rule, commonly referred to as the "Medical Listings," is published in regulations (Appendix 1 of subpart P of part 404 of the Social Security regulations). The Medical Listings describe specific diagnostic signs, symptoms, and clinical laboratory findings for various common impairments which are considered severe enough to ordinarily prevent a person from doing any gainful activity on an ongoing basis. If the signs, symptoms, and findings for the claimant's impairment meet those listed in the regulations, the claimant is allowed benefits on the basis of meeting the Listings. If not, but the claimant suffers from several impairments, the claimant may be found to be disabled on the basis that, in combination, these impairments equal in severity an impairment found in the Medical Listings.

If the claimant is not found to be disabled on the basis of the medical criteria in the Listings, a determination is made of the claimant's residual functional capacity (RFC). Residual functional capacity is the claimant's physical and mental ability to perform various types of work-related functions. Assessment of residual functional capacity requires consideration of both exertional impairments (those limiting strength) and nonexertional impairments (e.g., mental, sensory, or skin impairments). Once the claimant's RFC has been established, a judgment is made as to whether the claimant is able to perform his or her relevant past work. If it is found that the past work can be performed, the claim will be denied.

If the claimant is found to be unable to do his or her previous work, the next step in the process is to evaluate the factors of age, education, training, and work experience in conjunction with whatever residual functional capacity the claimant has been found to possess. This assessment, in turn, is used in deciding whether the claimant can perform any other jobs which exist in significant numbers in the national economy. The medical-vocational rules that guide this last step in the evaluation are set forth in regulations.

There are three tables in the medical-vocational rules, one for each of three levels of RFC—ability to do medium work, light work, or only sedentary work. (Impairments which do not preclude performance of heavy work are generally considered to be nondisabling.) Administrative notice has been taken of the fact that a number of jobs exist in the national economy that can be performed by persons with each level of RFC. The tables, in addition, relate the requirements of such jobs to the vocational factors of age, education, and prior work experience. The regulations specify that the medical-vocational rules will direct decisions on cases in which a claimant's RFC is significantly affected only by exertional impairments and the claimant's RFC, age, education, and work experience match those attributes in the table. They do not direct decisions on disability for claimants with solely nonexertional impairments, and do not specifically direct conclusions on disability for claimants with combinations of exertional and nonexertional impairments. In these types of cases, the medical-vocational rules are to be used as a guide, or general framework, for determining disability.

C. The Disability Decision System—Structure and Process

The disability determination process, which is essentially the same for both DI and SSI disability and blindness claims, can involve decisions at five distinct levels. The structure and procedures of each decision level (prior to P.L. 96-265) are discussed briefly below.

1. Initial Determination by SSA District Offices and State Agencies

Applications for DI and SSI disability benefits are filed by claimants in one of SSA's district offices. The district offices accept applications, obtain the names of the physicians, hospitals, or clinics that have treated the claimants, and make all the nonmedical eligibility determinations based on such factors as insured status, work activity, and for SSI claims, income and resources. If the claim is denied because the applicant does not meet these nonmedical eligibility requirements, a formal notice is sent.

A claimant's application, any medical records he or she may have provided, lists of sources of medical evidence, and other background information obtained during the district office interview are forwarded to the disability determination service (DDS) in the claimant's home State. The DDSs are State agencies and are usually components of State vocational rehabilitation agencies. Their total operating costs are paid by SSA.

The DDS requests detailed medical reports from physicians who have treated the claimant. This procedure uses clinical and laboratory findings in the files of treating physicians and has been successful in expediting the gathering of complete medical information and in limiting the need for purchased examinations. However, if sufficient medical information cannot be obtained in this manner, the DDS may purchase a consultative examination—that is, ask the claimant to be seen by a private physician selected by the DDS. The DDS may also seek more information pertaining to the claimant's education and work experience from the claimant.

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After the required evidence has been obtained, a two-person DDS team consisting of a physician and a lay disability examiner makes a decision on the claim. The DDS physician determines from the medical evidence the extent to which physical or mental limitations exist, whether the impairment meets or equals the Medical Listings and, when required, assesses residual functional capacity. The DDS lay examiner determines whether, with those limitations, the claimant can or cannot perform substantial gainful activity in jobs that exist in the national economy, based on the claimant's age, education, and work experience. DDS determinations are then issued as Federal decisions and the claimant is notified of the decision. If the claim is denied, the formal notice indicates why and advises the applicant of his or her appeal rights.

2. Reconsideration by State Agencies

Claimants whose applications are denied have a right to have their claims reconsidered, but must file for reconsideration within 60 days after receiving notice of the denial. The reconsideration decision is also made by the DDS. Additional evidence may be submitted by the claimant or requested by the DDS. The reconsideration decision process is similar to the initial disability decision process except that, after the district office updates the claimant's file, a different DDS team reviews the claim. If denied again, the claimant is given notice and advised of further appeal rights.

3. Hearing Before an Administrative Law Judge

If the DDS reconsideration team upholds the initial denial, the claimant may request a formal hearing before an administrative law judge in the SSA Office of Hearings and Appeals (OHA). The claimant must file a request for the hearing within 60 days after receiving notice of the reconsideration determination. These requests are forwarded to one of SSA's hearing offices located across the nation and are assigned to individual ALJs. Hearings are held as soon after the request as possible.

The ALJ is an experienced attorney who has received training in adjudicating disability claims. The ALJ is responsible for perfecting the evidentiary record, holding face-to-face nonadversary hearings, and issuing decisions. At the hearing, the claimant appears for the first time before a decisionmaker. Testimony is taken under oath and recorded verbatim. The ALJ may request the appearance of medical and vocational experts at the hearing and can require claimants to undergo consultative medical examinations. Claimants may submit additional evidence, produce witnesses, and be represented by legal counsel or lay persons. The hearing is nonadversarial whether or not the claimant is represented. There is no charge for requesting a hearing.

4. Appeals Council Review

Following an ALJ's decision to deny a claim, the claimant may, within 60 days after receiving notice, request the Appeals Council to review the decision. The Appeals Council is a 15-member body located in the Office of Hearings and

Appeals. The Appeals Council may deny or grant a request for review of an ALJ's action. If the Council agrees to review, it may uphold or change the ALJ's action or it may remand the case to an ALJ for further consideration. It may also review any ALJ action on its own motion within 60 days after the date of the ALJ's action.

5. Federal District Court

The Appeals Council review represents the Secretary's final decision and is the claimant's last administrative remedy. If the Council affirms the denial of benefits or refuses to review the claim, further appeal may only be made through the Federal district courts.

D. Adjudicative Standards, Instructions, and Procedures

In adjudicating disability claims, the DDSs, the ALJs, and the Appeals Council are all governed by the provisions of the Social Security Act, the regulations that have been published in the Code of Federal Regulations, the Social Security Rulings, and decisions of the Supreme Court. Social Security Rulings amplify SSA's policies and provide interpretations of the Act and regulations. Rulings are based on case decisions, program policy statements, decisions of the administrative law judges and the Appeals Council, opinions of the Secretary's Office of the General Counsel, Social Security Commissioner's decisions, Federal court decisions, and other interpretations of the law and regulations. The Rulings are used to make precedential decisions available to adjudicators and the public. Like the regulations, they are binding on all adjudicators.

In order to explain and further clarify the provisions of the law, regulations, and rulings, SSA issues to the DDSs a detailed set of administrative instructions known as the Program Operating Manual System (POMS). These guidelines are an amplification of, and are consistent with, the law, regulations, and rulings. The POMS sets forth the objectives and requirements of the disability programs and furnishes specific standards and procedures with which the DDS must comply in reaching a disability determination. These administrative instructions have been developed to ensure the uniformity of DDS and SSA operations and include, for example, standards for developing and evaluating disability evidence. The DDSs, but not the ALJs, are required to use the POMS in making disability determinations. The result has been that in certain policy areas the two adjudicative levels operate with different standards.

SSA also supplements the POMS by supplying the DDS with an Informational Digest. The Digest contains a collection of discussions and resolutions of questions concerning various disability policy and procedural statements. Although it is not to be cited as authority or as a basis for adjudicating claims, the Digest is designed to provide more detailed discussion of the meaning and intended application of disability program provisions.

While the POMS contains the standards used by the DDSs in adjudicating disability claims, it does not have the force or effect of law, as do the regulations. Therefore, in reaching a decision on a claim, an ALJ is not bound by the administrative instructions and guidelines that SSA issues in the POMS to the DDS. Instead, ALJs rely on the law and SSA's regulations and rulings in making disability decisions.

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E. Trend Data on Disability Insurance Decisions and Allowance Rates

During the early and mid-1970's the volume of Disability Insurance claims rose sharply. The number of initial disability decisions increased from about 800,000 in 1970 to about 1,350,000 in 1977. During the period 1978-80, initial decisions were stable at just over 1,000,000 per year, somewhat lower than the level of the mid-1970's but above the level experienced in 1970. Between 1970 and 1978, DDSs allowed around 40 percent of the initial claims they received and denied around 60 percent. However, beginning in 1979 the DDS allowance rate declined substantially, to about 37 percent in 1979 and 33 percent in 1980. The trends in volume and outcome of both DDS and ALJ decisions are shown in Charts 1 and 2.

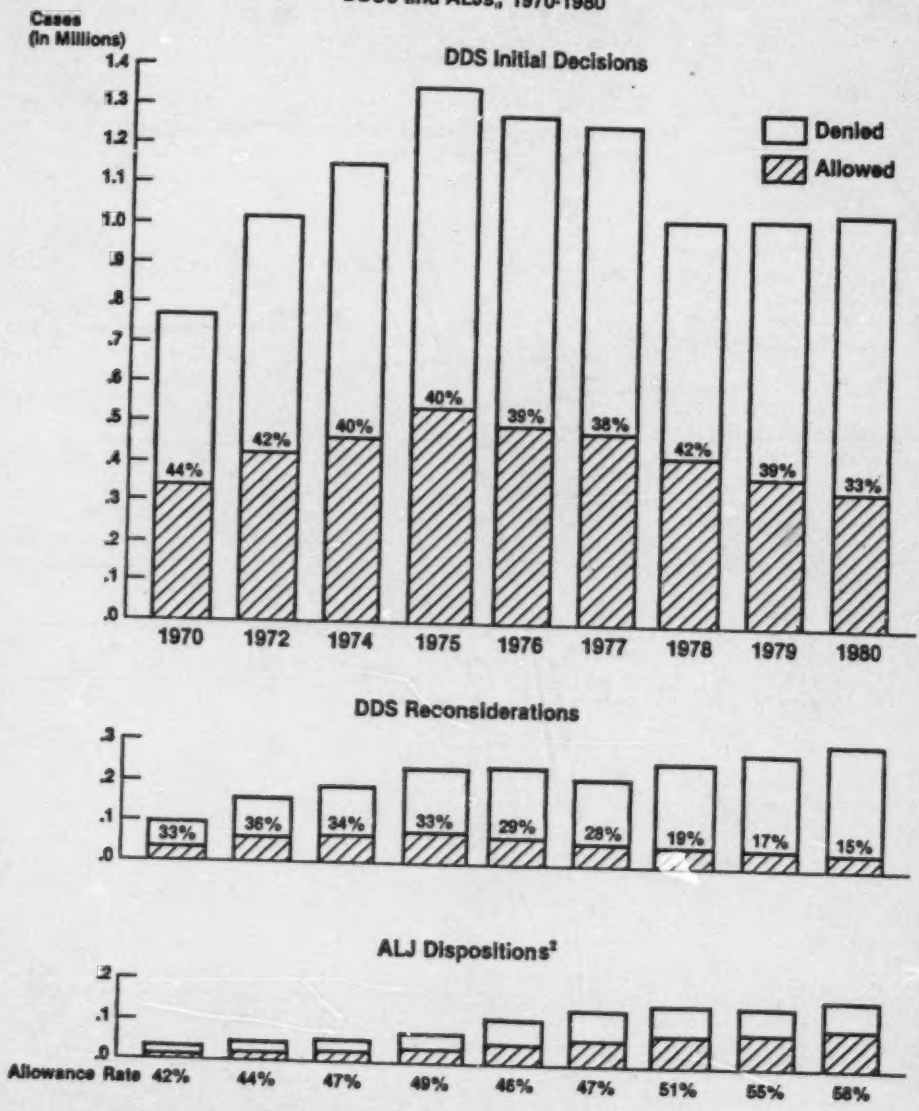
The greater volume of initial Disability Insurance claims and higher denial rate at the initial level has been accompanied by an increase in the volume of reconsideration requests at the State agency level. In 1970, DDSs made just under 100,000 reconsideration determinations. The number rose to over 200,000 in 1975 and was about 300,000 in fiscal year 1980. Between 1970 and 1975, the DDSs allowed at reconsideration roughly one-third of the claimants who had appealed the initial decision. This reconsideration allowance rate declined somewhat in 1976 and 1977 and it has declined again in the years since 1978. In 1980 only 15 percent of the reconsideration requests resulted in allowance of the claims.

Over the past decade there was a sharp increase in the number of denied applicants requesting a hearing before an ALJ. The number of ALJ dispositions rose from about 34,000 in fiscal year 1970 to about 75,000 in 1975 and then to 172,000 in 1980. During this period the ALJ allowance rate rose from 42 percent in 1970 to 49 percent in 1975 and to 58 percent in 1980. 1/

The trend in the number of Disability Insurance benefit awards from all sources (initial and reconsideration allowances and allowances by ALJs, the Appeals Council, or the Courts) has shown a continuing decline since the record high in 1975. Between fiscal year 1971 and 1975, the annual number of disabled worker benefit awards rose from 406,000 to 603,000. This dropped to 392,000 in fiscal year 1980 and to 358,000 in fiscal year 1981.

1/ ALJ allowance rates represent cases allowed as a percent of total ALJ dispositions, which include dismissals and remands. When allowance rates are expressed as a percent of total ALJ decisions, excluding dismissals and remands, they are higher (e.g., around 62 percent in 1980).

Chart 1. — Number of Disability Insurance Determinations[1] and Number Allowed by DDSs and ALJs, 1970-1980



[1]Includes DI/SSI concurrent claims but excludes claims which are solely for SSI disability benefits.
[2]Cases not allowed include denials, dismissals and remands to the DDS.

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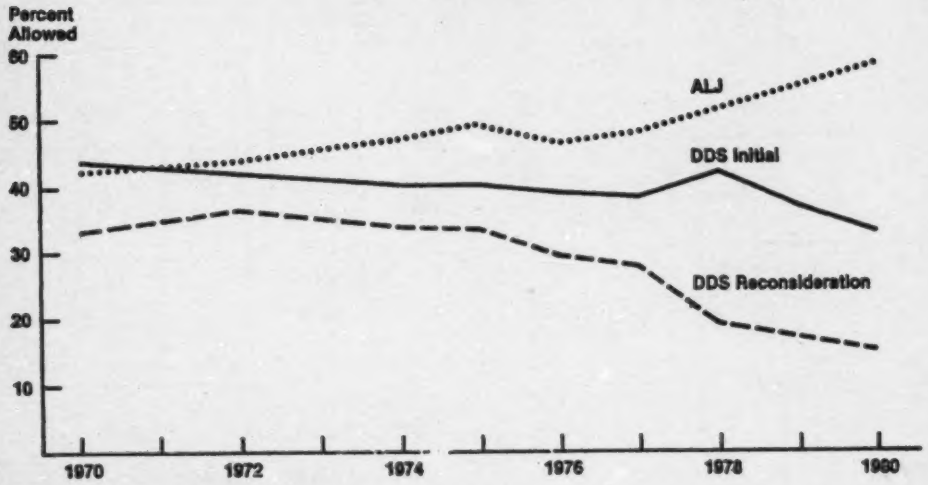
Chart 2. — Disability Insurance Allowance Rate* for DDSs and ALJs, 1970 — 1980



*For DDSs, percent allowed of determinations made.
For ALJs, percent allowed of dispositions.

III. Findings of an Initial Review of ALJ Decisions

Prior to implementing the ongoing review of ALJ decisions on disability claims required by section 304(g) of P.L. 96-265, SSA conducted an initial review of a representative sample of ALJ disability decisions. (A detailed technical description of the initial review is provided in the Technical Appendix to this report.) The purpose of the initial review was to provide information on the sources of differences among ALJ, Appeals Council, and DDS decisions. This information was intended both to serve as the basis for a report to the Congress on own-motion review, and to provide base-line data for developing an effective, ongoing own-motion review program and improving the consistency and accuracy of the disability adjudicative process.

A. Overall Differences in Disability Decisions

The first phase of the initial review was designed to determine whether, and to what extent, the standards, procedures, and practices of the DDSs, the ALJs, and the Appeals Council produce different results when the same cases are adjudicated by these different decisionmaking units. This phase involved a review of 3,600 recent ALJ decisions on Disability Insurance and SSI claims, of which approximately two-thirds were allowances and one-third were denials. The cases were randomly selected to represent a cross-section of all ALJ decisions made during the period September 1980-January 1981. The case files were reviewed by two different units within SSA: the Office of Assessment (OA), which operated under the rules governing the DDSs; and the Appeals Council, which applied the standards governing ALJ decisions. Neither of these units was aware of the ALJ decision on any case which they reviewed, nor did they see the claimant. Their review did not alter the formal agency decision on any of the cases.

The Office of Assessment review was conducted by disability examiners in that office, working in conjunction with physicians on the Medical Consultant Staff in the SSA Office of Disability Programs. This team of examiners and physicians, in most respects similar to the adjudicative team employed in the DDS, made decisions on each case by applying the POMS guidelines that all DDS agencies are required to use. Because the Office of Assessment, assisted by the Medical Consultant Staff, is the SSA organization responsible for assessing the quality and accuracy of DDS disability determinations on an ongoing basis in the Disability Insurance and SSI disability programs, and because they apply the same standards and procedures employed by the DDSs in adjudicating cases, their decisions on cases in this initial review were used to represent the "correct" application of DDS standards.

After the Office of Assessment determined that a case should be allowed or denied, that decision was compared with the original ALJ decision on the case. All cases in which OA disagreed with the original ALJ decision were sent to the Appeals Council for review. In addition, 300 cases in which there was no disagreement between OA and the ALJ were also sent to the Appeals Council. This procedure was designed to prevent any inadvertent bias in the Appeals Council review and to insure statistical comparability with the original sample. Because of the mixture of cases being sent to it, the Appeals Council was not aware of either the original ALJ decision or the OA decision on a case it was reviewing.

The Appeals Council conducted a de novo review of each case sent to it, applying the standards governing ALJ decisions. The Council reached a decision to allow or deny on each of the 2,183 cases it reviewed. Since the Appeals Council employs the same standards as those governing the ALJs and is the Secretary's final review authority on all disability decisions, its decision on a case was used to represent the "correct" application of the standards and procedures under which ALJs adjudicate claims.

This first phase of the review, therefore, produced three different decisions on the same cases: the OA decision, representing the "correct" application of DDS standards; the Appeals Council decision, representing the "correct" application of ALJ standards; and the original ALJ decision itself. The major finding—which dominates both this and other portions of the review—was that significant differences in decision results were produced when these different decisionmakers were presented with the same evidence on the same cases. The most striking finding is that ALJs allowed 64 percent of the cases while OA allowed only 13 percent. The disparity between the original ALJ decision and the Appeals Council decision was not as great: the Appeals Council allowed 48 percent of the cases. Thus, the Appeals Council occupied a "middle ground," but one which was markedly closer to the ALJ decisions than to the OA decisions.

The allowance and denial rates of these three groups of decisionmakers, broken down by basis for decision, are shown in Table 1.

Table 1. Percent Distribution of Sample Case Allowances and Denials, by Decision-maker and Basis for Decision 1/

	Original ALJ Decision	Appeals Council Decision	Office of Assessment Decision Using DDS Standards
ALLOWANCES			
Total	64%	48%	13%
Medical alone	18	15	6
Medical/Vocational inability to engage in SGA:			
Directed by medical-vocational rule	14	11	5
Specific reasons:			
RFC less than sedentary	18	9	0
Pain combined with significant impairment(s)	5	3	0
Mental disorders combined with significant physical impairment(s)	5	4	(2/)
Other medical/vocational	5	6	2
DENIALS			
Total	36	52	87
Impairment not severe	11	16	39
Impairment does not prohibit past work	9	13	28
Directed by medical-vocational rule	13	19	13
Impairment does not prohibit other work	1	2	4
Other	2	3	3

NOTE: Detail may not add to totals due to rounding.

1/ Percentages shown are for the combined total of DI and SSI claims. Although there are some differences between the allowance/denial rates for DI claims and SSI claims (e.g., the Appeals Council would have allowed about 49% of DI claims and 45% of SSI claims), these differences do not appear to be significant and do not affect the findings of the review.

2/ About 0.4%.

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A comparison of the extent of agreement or disagreement on individual cases reveals even greater differences among the decisionmakers. The original ALJ allowance rate was 64 percent and the Appeals Council allowance rate was 48 percent. This does not mean, however, that the Appeals Council simply denied all the cases which the ALJs denied and, in addition, denied a proportion of the cases which the ALJs allowed. Had this been the case, the Appeals Council allowance rate of 48 percent would have resulted from denying about one-quarter of the ALJ allowances. What actually happened, as shown in Table 2, is that the Appeals Council denied 37 percent of the cases which ALJs allowed and allowed 21 percent of the cases which ALJs denied. Conversely, the Council agreed with the original ALJ decision to allow in only 63 percent of the cases, and agreed with the ALJ decision to deny in 79 percent of the cases. The Office of Assessment decisions on ALJ (Table 2) and Appeals Council (Table 3) denials reflect much greater agreement. Nonetheless, OA would have allowed 4 percent of the cases which the ALJs denied and 7 percent of the cases which the Appeals Council would have denied.

Table 2. Tabulation of Appeals Council and Office of Assessment Decisions by Type of ALJ Decision

	ALJ Allowances	ALJ Denials	All Cases
Decision of Reviewers			
Appeals Council			
Allow	63%	21%	48%
Deny	37	79	52
Office of Assessment			
Allow	18	4	13
Deny	82	96	87

A similar comparison of OA decisions on cases allowed and denied by the Appeals Council is shown in Table 3.

Table 3. Office of Assessment Decisions on Appeals Council Decisions to Allow or Deny (Appeals Council Subsample) 1/

	Appeals Council Allowances	Appeals Council Denials	All Cases 1/
Office of Assessment Decision			
Allow	22%	7%	14%
Deny	78	93	86

1/ Totals differ slightly from those shown in Tables 1 and 2 because Tables 1 and 2 are based on full sample while Table 3 is based on smaller Appeals Council subsample.

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B. Explanation of Differences

From the data presently available, there is no way to account precisely for all the causes of the differences or their relative importance. Based on what we know about the disability program and what the initial review data tell us, it is clear, however, that there is more than one cause. The initial review was structured to identify significant reasons for the differences, although it cannot establish conclusively all the various contributing factors. In the sections that follow we will discuss some of these possible causes, explain each, and review the evidence available.

1. Differences in Standards and Procedures

SSA has long recognized that the standards and procedures governing decisions by DDSs and ALJs are not entirely consistent. Where inconsistencies exist, they are, at least in part, an outgrowth of two somewhat different systems of adjudication. The rules governing DDSs, on the one hand, have developed over time as detailed instructions governing an administrative system. This system is not an independent adjudicative body, and the decisionmaker has no direct face-to-face contact with the claimant. The standards and procedures followed by ALJs, on the other hand, to some degree reflect the status of the ALJ as an adjudicator having decisional independence, conducting hearings in a quasi-judicial setting involving face-to-face contact with claimants, their representatives, and expert witnesses, and taking cognizance of rulings of the U.S. District and Circuit Courts on individual disability claims.

The ALJs are governed by the law, program regulations, and Social Security Rulings. Guidance is also provided by various handbooks issued by the Social Security Administration. The DDSs must follow the POMS, which amplify the basic standards contained in the law and regulations, and are also governed by policy interpretations contained in the SSA Rulings. A review of the standards and procedures governing the ALJs and the DDSs indicates that there are distinct differences in certain key areas. These differences are of several kinds. In certain instances, as for example the definition of "impairment not severe," the actual definition contained in the standards governing the ALJs and the DDSs is not precisely the same. In other instances, ALJ practices result in findings that are not possible under the DDS standards. Finally, in some areas the definitions contained in the standards may be the same—the Medical Listings are the primary case in point—but the procedures actually used for evaluating evidence to determine whether or not an individual's impairment meets the definitions are often quite different. Major areas in which the DDS and ALJ standards and procedures differ are discussed below.

a. Medical Definitions and Evidence

The first step in adjudicating a disability claim, provided the claimant is not working, is to determine the individual's medical condition. If the individual's impairment is found to be medically "not severe," the claim is denied. Conversely, if the individual meets or equals the Medical Listings, the claim is allowed, since the impairments listed are considered severe enough to prevent any substantial work (substantial gainful activity). If either of these two sets of medical criteria are met, no further development of the claim is required. Our evaluation of the review data revealed the following pattern of decisions based on medical evidence alone.

Table 4. Decisions Based Solely on Medical Evidence (Percentage of All Decisions)

	Original ALJ Decision	Appeals Council Decision	Office of Assessment (DDS) Decision
Allowance—Meets or Equals Medical Listings	18%	15%	6%
Denial—Impairment Not Severe	11	16	39
TOTAL	29	31	45

Table 4 illustrates that the Office of Assessment made substantially more decisions based on medical evidence alone than did the ALJs or the Appeals Council, and that the OA interpretation of the medical evidence was much different, particularly with regard to a finding of "impairment not severe." Although there may be a variety of factors which influence these outcomes, we believe that two are particularly significant.

First, there appear to be differences in the operational definitions of "impairment not severe" which are applied by the two sets of decisionmakers. The regulatory definition used by the ALJs and Appeals Council is:

> A condition which does not "significantly limit your physical or mental ability to do basic work activities . . . ."

The POMS guidelines used by the DDSs and OA are more inclusive:

> "When there is no significant limitation in the ability to perform these basic work related functions, an impairment will not be considered to be severe even though it may prevent the individual from doing a highly selective group of jobs, including work that the individual has done in the past."

Judging from the review data, these two standards, as they are interpreted by the adjudicators, result in widely different findings based on the same evidence. Because the standards, while different, are not widely divergent, the disparities in decisions reflected in the review data would suggest that the views of and procedures used by the different adjudicative bodies in applying the standards are not the same.

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Second, although the Medical Listings used by all adjudicators are the same, the evaluation of medical evidence can be quite different. Under the POMS procedures applicable to the DDSs and OA, a physician in the employ of the government must review objective medical findings supplied by a claimant's treating physician or other medical source and make an independent judgment as to whether or not these objective findings indicate that the claimant does not have a severe impairment or is medically disabled. The findings of the government physician, who is trained in the application of the medical criteria used in the disability program, provide the medical basis for disability determinations made by the DDSs and OA. These findings are not supposed to be influenced by a treating physician's conclusions that a claimant is "disabled" or "unable to work."

In contrast, it appears that many ALJs give considerable evidentiary weight to a conclusion reached by a claimant's treating physician or a consulting physician that the individual is medically disabled. This practice may be due, in part, to the fact that ALJ's are lawyers, not physicians, and are therefore reluctant to reach an independent medical conclusion (despite the fact that program regulations specify that medical determinations should be based on the adjudicator's review of medical findings and other medical evidence). This practice may also be influenced by the approach required to be taken by the Federal courts. The courts apply a "substantial evidence" rule, under which the conclusion of a physician who has examined the claimant will generally be accorded more weight than the conclusion of a government physician who has only reviewed the paper record, provided that the examining physician's conclusion is supported by substantiating medical data.

Thus, in assessing medical evidence provided by treating or consulting physicians, the DDS and OA will give primary weight to objective evidence and only limited weight to any conclusions as to disability made by the medical source, relying instead on the government physician's conclusions. The conclusions of the treating physician, on the other hand, are often given significant evidentiary weight by the ALJ.

b. Ability or Inability to Engage in Substantial Gainful Activity

If an individual's disability claim cannot be allowed or denied based on medical factors alone, the DDS must go further to determine whether or not a combination of medical and vocational factors prevent the claimant from engaging in substantial gainful activity. A finding of inability to engage in SGA results in an allowance; ability to engage in SGA results in a denial.

The first step in cases of this type is to perform an assessment of the claimant's residual functional capacity—his or her ability to perform a variety of work-related activities. (The RFC determination is basically a medical determination, subject to the same difference in procedures between DDSs and ALJs cited earlier.) A determination is then made as to whether or not the RFC will permit the individual to perform work done in the past. Ability to do past work results in a denial.

If past work cannot be performed, the adjudicator is required to make a medical-vocational determination as to whether or not the claimant can perform other work in the economy. This is usually done through application of medical-vocational rules which take into account residual functional capacity and the vocational factors of age, education, and previous work. When an individual's impairments are entirely of an exertional nature—limitations in meeting the strength requirements of jobs—the medical-vocational rules generally direct a determination as to whether or not an individual is able to engage in SGA. When the impairments are both exertional and nonexertional (e.g., physical limitations combined with sensory impairments), the medical-vocational rules are first used to determine whether an individual is precluded from engaging in SGA based on exertional impairments alone. If not, the rules are then used by the adjudicator only as a "framework" for determining whether or not the combination of exertional and nonexertional impairments is disabling. They do not direct a finding of disabled or not disabled.

The regulatory standards governing the DDSs and the ALJs provide for this same basic determination process. ALJ practice also permits a determination of inability to engage in SGA if the individual:

(1) has a residual functional capacity less than sedentary (i.e., the individual cannot perform even sedentary work);

(2) suffers from severe pain which, combined with significant impairment(s), precludes performance of SGA; or

(3) suffers from a nonsevere mental disorder which, combined with significant physical impairment(s), precludes performance of SGA.

These three categories either do not exist, or are used infrequently, in the DDS determination process. The first two categories are not provided for in regulations or in the POMS, and are not used at all by the DDSs. Under the DDS standards, the category "RFC less than sedentary" is nonexistent; to have less than sedentary residual functional capacity means that an individual has impairments which should meet or equal the Medical Listings. The DDSs do consider pain in making a medical-vocational determination. The regulations require that they treat pain as a symptom associated with certain physical impairments, not as an impairment itself, and take it into account when determining residual functional capacity. Thus, pain could be a factor in a determination of disability made by the DDSs using the medical-vocational rules, but would not be a basis for a separate finding of disability under a special "pain" category.

Finally, although the third category—the combination of mental disorders with significant physical impairments—is provided for in the regulations and can appropriately be used by the DDSs, its use in making a medical-vocational allowance appears to be infrequent. (Of course, if the combination of impairments is sufficiently severe, it will result in a medical allowance based on equaling the Medical Listings.) A medical-vocational finding of disability resulting from this combination of exertional and nonexertional impairments is judgmental, not one which is directed by the medical-vocational rules.

These three categories are, however, used extensively by ALJs and the Appeals Council. This is clearly shown in Table 1, where the initial review data indicate that 28 percent of the ALJ cases and 16 percent of the Appeals Council cases were allowed based on a finding that an individual could not engage in SGA due to one of these three causes. The preponderance of such allowances by both sets of decisionmakers was based on a finding of "RFC less than sedentary." In contrast, the Office of Assessment, applying the DDS standards, made no allowances in the "RFC less than sedentary" and "pain" categories, and allowed only 0.4 percent of the cases under the third, or "mental," category. Although pain or mental illness may have been a factor in some OA allowances recorded under other categories in Table 1 (e.g., the "Other medical/vocational" category generally used by OA when a decision was not directed by the medical-vocational rules), the overall OA allowance rate of 13 percent suggests that pain and mental illness could not have been significant factors—particularly when compared with an ALJ allowance rate of 19 percent and an Appeals Council rate of 7 percent in these categories.

It should be noted that eliminating the ALJ practice of using the first two categories would not necessarily convert allowances under these categories to denials. A preliminary and informal study by the SSA Office of Hearings and Appeals has indicated that most of the claims allowed on the basis of "RFC less than sedentary" might be allowed under other categories. In any event, we cannot say with any certainty what the effect of elimination of the categories would be.

The data in Table 1 also appear to indicate that the evaluation of residual functional capacity, as it applies to a claimant's ability or inability to do past work, is viewed quite differently by the various adjudicatory authorities. The ALJs denied claims on the basis of ability to do past work in 9 percent of the cases, and the Appeals Council denied in 13 percent. The Office of Assessment denial rate, 28 percent, was 2 to 3 times higher. There is no clear explanation for this difference, but it may be related to such factors as the differences in treatment of medical evidence used to determine an individual's RFC, and differences in the findings of vocational experts available to or used by the adjudicators.

In summary, an evaluation of the standards and procedures governing the ALJs and DDSs suggests that variations in definitions and procedures may well be an important cause of the difference in findings, based on the same evidence, observed in the data from the initial review shown in Table 1. It is important to note, however, that differences in allowance and denial rates among the various adjudicators are not solely a product of differences in standards and procedures.

2. Inconsistencies in the Application of Standards

The initial review indicates that, even when decisionmakers are supposed to be applying the same standards, they are not applying them consistently. Data presented in Tables 1 and 2 show that ALJs and the Appeals Council arrive at different conclusions when reviewing the same cases, even though they are using the same standards. In the aggregate, the Appeals Council would have allowed significantly fewer cases than ALJs.

In addition to studying overall allowance and denial rates, the initial review attempted to measure the consistency of decisionmaking among ALJs. The SSA corps of ALJs was divided into three groups of approximately equal size. Each group was composed of ALJs whose overall allowance rate fell within a given range. The sample of ALJ decisions selected for the first phase of the review was structured so that about one-third of the cases came from each group of ALJs. The three groups of ALJs, classified by their allowance rate levels, were:

ALJ Allowance Rate Group	ALJ Allowance Percentage	ALJ Median Allowance Rate
Low Allowance Rate	0-55%	47%
Medium Allowance Rate	56-70%	63%
High Allowance Rate	71-100%	77%

The initial review was not designed to take into account all of the factors that might account for differences in ALJ allowance rates (e.g., the possibility of significant differences in the types of cases assigned to high or low allowance ALJs, or differences in attorney representation of claimants among the three ALJ strata). Initial evaluation of the data, however, suggests that while it is possible that some biases exist, they would not be significant enough to alter the nature of the results found when the original ALJ allowance rates are compared with the Appeals Council rates for the three groups of ALJs. These results are shown in Table 5.

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Table 5. Appeals Council Allowance Rate for ALJ Groups with Low, Medium, and High Allowance Characteristics (Appeals Council Subsample)

ALJ Allowance Rate Group	Original ALJ Decision on Sample Cases		Appeals Council Allowances: Percent of ALJ Decisions Allowed		Appeals Council Allowance Rate
	(1)	X	(2)	=	(3)
Low Allowance Rate Group					
Allow	50%		70%		35%
Deny	50		24		12
Total					47
Medium Allowance Rate Group					
Allow	65		68		44
Deny	35		19		7
Total					51
High Allowance Rate Group					
Allow	81		52		43
Deny	19		17		3
Total					46
Total, All ALJs					
Allow	64		63		40
Deny	36		21		8
Total					48

Table 5 shows that the Appeals Council allowed roughly 50 percent (ranging from 46-51 percent) of the cases from each of the three groups of ALJs. This relatively consistent Appeals Council allowance rate across the groups does not follow the pattern of high, medium, and low allowance rates that characterize the groups, and suggests that there are not major variations in the characteristics of cases decided by each group. The Appeals Council allowance rates for cases that the low and medium allowance rate ALJs originally allowed were consistent: 70 and 68 percent, respectively. However, the Appeals Council allowance rate for cases originally allowed by ALJs with high allowance rates dropped to 52 percent.

If the Appeals Council decision is taken as the "correct" decision under the standards and procedures governing ALJs, these findings would indicate that decisions to allow cases by ALJs with high allowance rates are more often "incorrect" than the decisions of ALJs with medium and low allowance rates. By the same token, no significant difference is found in Appeals Council decisions on cases originally decided by the ALJ groups with medium and low allowance rates. These two groups appear to be relatively homogeneous, using Appeals Council decisions as the criterion. This clearly suggests that the ongoing, own-motion review mandated by P.L. 96-265 should place the most emphasis on a review of cases decided by ALJs with high allowance rates.

The initial review also indicates that a more subtle form of inconsistency, or subjectivity, exists in disability decisions. Its essence is that while two different decisionmakers or sets of decisionmakers may often make the same decision to allow or deny a particular case, their reasons for making that decision and their view of the evidence on which the decision is based may be quite different. When the Appeals Council reviewed the ALJ decisions in the initial review, they allowed 63 percent of the cases which the ALJs allowed and denied 79 percent of the cases which the ALJs denied (see Table 2). A detailed examination of the cases on which both groups agreed, however, shows that the Council agreed with the ALJs as to the basis for an allowance or denial much less frequently than it agreed on whether the case should be allowed or denied. The Council agreed that a case should be allowed because the claimant met or equaled the Medical Listings in 41 percent of the cases that the ALJs allowed on this basis, and agreed with an ALJ allowance based on vocational rules in 38 percent of the cases. The rate of agreement on the basis for allowance due to all other allowance criteria was significantly lower. The same phenomenon is observed, although to a lesser degree, in those cases which both the ALJ and the Appeals Council denied.

In short, although there was a fair amount of agreement as to whether a case should be allowed or denied according to the standards governing ALJs, there was significantly less agreement on the basis for reaching that decision. It seems obvious that when these kinds of variations occur in decisions on cases in which the decisionmakers agree upon the outcome, there is a considerable degree of latitude for the individual judgments of different decisionmakers to produce a different outcome on the same case. Although it may be possible by various means to lessen inconsistency in the determination process, one cannot necessarily expect that two different decisionmakers or decisionmaking levels operating under the same rules and procedures will uniformly produce the same decision results on the same cases.

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3. Subjectivity, Organizational Trends, and Management Emphases

SSA has long recognized that determining whether an individual is capable of engaging in substantial gainful activity—the basic measure of whether or not one is disabled under the law—is a complex process. By its very nature, the process involves some degree of subjective judgment by the adjudicator, especially in cases where the claimant's condition is near the border that divides the disabled person from one who is not disabled. The data presented in the previous section concerning inconsistency in decisionmaking are, to some degree, indicative of this subjective element.

There are indicators that the subjective element in the disability determination process, in combination with other factors, may result in distinct differences and trends in disability decisions made at different organizational levels. These differences seem to reflect organizational bias and change, as opposed to random inconsistency in the application of standards by individual disability decisionmakers.

When we review the Disability Insurance program allowance and denial data for the past 10 years, we find definite trends or changes which seem to be unaccounted for by any significant changes in the standards which govern the separate adjudicative bodies, or in the characteristics of the applicant population. As shown in the preceding chapter (Charts 1 and 2), allowance rates at the various decisional levels were relatively stable during the period 1970-77. DDSs allowed about 40 percent of initial Disability Insurance claims and 33 percent of reconsideration appeals. The allowance rate for ALJs hovered in the 45 percent range, varying from a low of 42 percent in 1970 to a high of 49 percent in 1975. This picture began to change dramatically in the latter part of the 1970's, however, as the DDS allowance rate started to decline. By fiscal year 1980 the DDS allowance rate on initial claims had dropped to 33 percent, and on reconsideration appeals to 15 percent.

The reconsideration claims volume and allowance rates are particularly worth noting, since a denial at reconsideration is the necessary precursor to an appeal for an ALJ hearing. The volume of reconsiderations in the latter part of the 1970's has been double or triple the volume in the first half of the decade, and continues to increase. At the same time, the allowance rate on reconsiderations, which was 33 percent in 1975, has steadily declined in subsequent years. It presently stands at less than half of the 1975 rate. What may very well be a reciprocal change has occurred in the ALJ allowance rates during the last few years. From an allowance rate level of 47 percent in 1977, the ALJ rate climbed to 51 percent in 1978, 55 percent in 1979, and 58 percent in 1980.

We cannot definitively establish why these trends occur or whether the trends in ALJ allowance rates were the result of changes in the DDS allowance pattern. There is no question, however, that a primary focus of the Social Security Administration in recent years has been to tighten administration of the disability program at the DDS level to attempt to minimize subjectivity and ensure that only those who were severely disabled were awarded benefits. This tightening was a reasonable and necessary response to the experience of the early and mid-1970's, when the combination of high application and allowance rates caused

program costs to quadruple. Various management processes—more explicit instructions, requirements for better documentation, increased physician participation in adjudication and review, greatly strengthened quality control—were used to accomplish this change. As a result, it is likely that a more stringent application of the subjective adjudicative standards has been in evidence in the last few years.

This hypothesis cannot be conclusively proven, but the trends in disability applications and DDS allowance rates, our knowledge of recent program and administrative emphases, quality assurance data, and anecdotal information from the DDSs all lend it credence. If one accepts this hypothesis, then it seems reasonable to assume that, within a limited range, the outcome of a disability determination may be a product of the general policies under which the adjudicator is operating and the nature and extent of quality control and other management procedures applied in the organization to reduce subjectivity and promote consistent interpretations of agency policy.

Carrying the hypothesis a step further, if steps to significantly tighten administration and quality review at the DDS level result in a higher percentage of reconsideration denials, this should have some effect at the hearings level. If ALJ behavior did not change appreciably when these denials were appealed to the hearings level—i.e., if individual ALJs continued to allow the same kinds of cases they previously had allowed—the overall ALJ allowance rate would increase. This is, in fact, what the data show. This is also consistent with the observation that, in recent years, the forces at work to tighten administration at the DDS level were largely absent at the ALJ level. While considerable attention was focused on increasing the production rate of ALJs, mechanisms such as an effective own-motion review designed to reverse incorrect decisions by ALJs were essentially absent.

The essential points are that a degree of subjectivity exists in the disability determination process, and that one of its manifestations may be different decisional behavior at different organizational levels. Available evidence at least suggests that this behavior, as reflected in historic trends, is influenced by the mind set of the various SSA adjudicatory organizations, the general policy and management framework in which they are operating, and the controls over decisional quality which are applied in the organizations.

C. Other Findings

As requested by the Congress, the initial review attempted to determine the effect of in-person appearance by the claimant before the ALJ and the effect of additional evidence submitted to the ALJ after the DDS reconsideration decision.

1. Effect of In-Person Appearance

The ALJ hearing is the first time an applicant appears before the person who decides his case. The second phase of the initial review was designed to determine the effect on ALJ decisions of the claimant's in-person appearance. In this phase, a representative subsample of 1,000 cases was selected from the 3,600

cases used in the first phase. For each case, a hard copy transcript of the original ALJ hearing was made and then edited to remove all evidence related to the claimant's in-person appearance at the hearing. Testimony of expert witnesses was retained in the edited transcript.

These 1,000 edited cases were then distributed to a representative sample of 48 ALJs (selected to mirror the allowance rate patterns of the ALJs who originally decided the cases) for a complete redetermination. The resulting decisions were then compared with the original ALJ decisions. Given that only one type of information available to the original ALJ was removed, the difference between the two sets of decisions should be indicative of the effect of the claimant's in-person appearance, absent any biases which might result from the study procedure itself. 1/

The original ALJ allowance rate on this subsample of cases was 63 percent. After removing the evidence relating to the claimant's in-person appearance, the ALJ allowance rate dropped to 46 percent. Thus, the in-person appearance of claimants appears to make a difference in ALJ decisions (subject to the previously noted caveats about a "study effect").

That in-person appearance might make a difference is not surprising. On a number of occasions SSA has experimented with in-person appearance at the DDS reconsideration level. While the specific results of the studies vary and there are certain reservations due to the methodology employed, they do generally show that the allowance rate increases somewhat when the decision process includes a face-to-face appearance by the claimant.

There could be a variety of reasons for this effect. Some of these may be of an objective nature: the decisionmaker can see at first hand the claimant's appearance and functional limitations. A more subjective, emotional effect—human sympathy for an individual who appears to be severely impaired--is probably also present is some cases.

1/ The way the study was designed and conducted could have influenced the results. The original ALJ decision was made with the knowledge that it would affect the benefit rights of the claimant. The second-phase decision, made by the representative sample of ALJs, was made with the knowledge that the decision would not affect benefit rights or benefit amounts. As a result, this decision may have been made more liberally or conservatively than it would have been had "live" claims been involved. This difference in the adjudicative climate in which the two sets of ALJs made their decisions could have introduced a "study effect" which might, at least in part, account for differences in decisional results. SSA is currently analyzing the study data to try to determine the magnitude of this possible study effect.

Still another factor which may be of relevance in ALJ determinations is the representation of some claimants by a lawyer or other advocate at the hearing. In FY 1981, 71 percent of claimants were represented at the ALJ hearing. In those cases where representatives were present, the ALJ allowance rate was 61 percent. In contrast, in the 29 percent of cases where claimants were not represented, the allowance rate fell to 48 percent. Data from the first phase of the initial review show a similar pattern. Of those claimants who had a hearing, 68 percent were represented. The ALJ allowance rate for those cases was 64 percent, as opposed to 53 percent for claimants not represented at hearing.

2. Effect of Additional Evidence Submitted at Hearing

The third phase of the initial review was designed to determine the effect on ALJ decisions of additional evidence submitted after the DDS reconsideration decision. This phase used all of the 1,000 cases used in the second (in-person appearance) phase. Each case was revised to remove any evidence added after the DDS reconsideration decision. The case folders, stripped of all information gathered in the hearings process, were distributed to another representative group of 48 ALJs for a complete readjudication. The resulting decisions were then compared with the decisions made in the second phase, where only the information related to in-person appearance had been removed. The differences in decisions on these 1,000 cases—adjudicated both with and without post-reconsideration evidence—should be, in the aggregate, attributable to the submission of additional evidence after the reconsideration level.

Table 6 shows that additional evidence made a significant difference in ALJ allowance rates. The overall second phase allowance rate of 46 percent dropped to 31 percent when all additional evidence was removed. A statistical test showed that the difference was due solely to additional medical evidence, which was submitted in 74 percent of the cases. Additional vocational evidence had no impact on allowance rates. Specifically, neither the difference in ALJ allowance rates shown in Table 6 for cases without any additional evidence, nor the difference for cases with additional vocational evidence only, was statistically significant. The effect of additional medical evidence is the same with and without additional vocational evidence.

The OA examiners and Medical Consultant Staff also reviewed this subsample of 1,000 cases with and without the additional evidence. The OA allowance rate was 15 percent when all the evidence available to the ALJ was included. It dropped to 12 percent when the additional evidence was deleted.

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Table 6. Allowance Rates Distributed by Type of Additional Evidence

Type of Additional Evidence	Total Cases	ALJ Allowance Rate		OA Allowance Rate	
		Without New Evidence	With New Evidence	Without New Evidence	With New Evidence
None 1/	20%	36%	40%	10%	11%
Vocational only	6	30	25	9	9
Medical only	50	29	49	12	15
Medical and Vocational	24	30	51	16	19
Total	100	31	46	12	15

Table 7 shows that of the sample cases with additional medical evidence, in almost all cases the evidence pertained to a previously alleged medical condition rather than to a new medical condition. The additional evidence concerning prior conditions may have shown a change in the prior condition or provided more extensive documentation of the condition as it existed at the reconsideration level.

Table 7. Percent of Cases Containing Medical Evidence Pertaining to Prior and/or New Condition(s)

Additional Medical Evidence Pertaining to:	Percent of Cases
New condition	1
Prior condition	88
Both new and prior condition	11

1/ In this instance, there was no difference between cases "without new evidence" and "with new evidence." As previously noted, the difference in allowance rates (4 percentage points) for the two groups of ALJ reviewers is not statistically significant. Neither is the difference in OA rates.

The relative importance of new evidence to the different disability decision-makers is worth noting. As observed earlier, there are significant differences in the way ALJs and OA view the same medical evidence. These differences are reflected in the much lower OA allowance rates shown in Table 1. Thus, it is not surprising that OA, working with the Medical Consultant Staff, found that only 12 percent of the cases in this subsample should have been allowed at the reconsideration level, and that the additional evidence submitted after reconsideration should have increased the allowance rate by only 3 percentage points, to 15 percent. Nonetheless, although this increase is small in absolute terms, it does represent a 25 percent increase over the base allowance rate of 12 percent.

The ALJs who reviewed the cases from which all additional evidence had been removed—cases which contained only the information on which the reconsideration decision was based—found that 31 percent should have been allowed at that stage. The ALJ allowance rate after the new evidence was reviewed increased by 15 percentage points, or an increase of 48 percent over the base allowance level. The treatment of additional medical evidence by the ALJs is a dominant factor in this increase. This may be reflective, at least in part, of the greater weight assigned by the ALJs to conclusions drawn by treating or consulting physicians. In any event, the discrepancy between the ALJ and the OA allowance rate for these cases is probably a product of the differences in standards, the inconsistency in the application of standards, and the other causal factors previously discussed.

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IV. The Ongoing Review and Other Initiatives

The initial review indicates significant differences in adjudicatory practices and results between the prehearing and the hearing levels, and to a lesser extent, inconsistencies within the hearing level. SSA is concerned about the implications of these findings and has undertaken, or will undertake, actions in a number of areas to address the identified problems. Generally, SSA initiatives address five areas of concern:

(1) The need to improve the consistency and correctness of ALJ decisions.

(2) The need to ensure that standards governing DDSs and ALJs are consistent and are applied in a consistent manner.

(3) The need to provide improved ALJ training to promote better understanding and more consistent application of agency policy.

(4) The need to ensure complete documentation and consideration of all relevant evidence in a case, and to provide a specific and detailed rationale for the decision reached at the hearing level.

(5) The need to examine and improve other aspects of the disability determination process, particularly at the reconsideration level.

A. An Ongoing Review

On October 1, 1981, SSA implemented an ongoing program of own-motion review pursuant to section 304(g) of P.L. 96-265. The purpose of the review is to identify decisions which are inconsistent with SSA policy and standards, and to take appropriate action to revise those decisions.

The review is being conducted in the Office of Hearings and Appeals by the Appeals Council, which has the delegated authority to review all ALJ decisions and dismissal actions at the request of the claimant or on its own motion. The review program concentrates primarily on ALJ disability allowances issued for Disability Insurance and concurrent DI/SSI claims. At the outset, based on results of the initial review, a sample of decisions of ALJs and hearing offices with the highest allowance rates is being selected. Cases from these ALJs and hearing offices are being forwarded directly to OHA's central office in Arlington, Virginia, where they undergo preliminary screening and review by staff of the Appeals Council. Where appropriate, referrals are made to the Appeals Council for consideration of own-motion action.

The Appeals Council will exercise its own-motion authority if any one of the following is present:

(1) There is an abuse of discretion by the ALJ;

(2) there is an error of law;

(3) the decision is not supported by substantial evidence; or

(4) there is a broad policy or procedural issue that may affect the general public interest.

Once the Appeals Council decides to review a hearing decision on its own motion, the Council may affirm, reverse, or modify the decision or remand the case to an administrative law judge for further proceedings.

The current review sample is intended to include approximately 7½ percent of total ALJ allowances in DI and DI/SSI concurrent cases. Later in fiscal year 1982, as additional resources can be made available for this effort, the review will be expanded to include additional ALJs and a national random sample of hearing decisions. By the end of FY 1982, we plan to be reviewing a total of 15 percent of ALJ allowance decisions. At present, we do not plan to include ALJ denial decisions in the review, since the Appeals Council will continue to handle those cases in which the claimant requests review of an ALJ decision denying his or her application in whole or in part.

In addition to ALJ decisions selected through a targeted sampling procedure, the review will also include decisions formally referred to OHA by other SSA components. Referrals from these components will be reviewed under what is commonly referred to as the "protest" procedure. Referrals will be made when the decision as to disability is questioned on a substantive issue rather than on a solely technical nondisability issue, as has occurred under past "protest" procedures. Generally, cases previously referred under "protest" have been those which could not be effectuated because of a legal or technical impediment.

Because the ongoing review program was only recently implemented, significant data about the results are not yet available. Nonetheless, SSA believes this program will bring about more accurate and consistent decisions by all administrative law judges. In some cases, the Appeals Council will be taking corrective action itself where an ALJ's decision is determined to be erroneous, based on the record upon which the decision was made. In other instances, the Appeals Council will return the case to an administrative law judge for corrective action, which may include obtaining additional evidence and/or a new or supplemental hearing. In either event, the administrative law judge who issued the original decision will receive specific feedback about the Council's action and the basis for it. Included will be specific instructions for correcting case deficiencies, as well as citations and discussion of relevant regulatory provisions. Apart from this direct feedback to the individual ALJ whose decisions are reviewed under the ongoing program, OHA also intends to use aggregate findings as a basis for advising the entire administrative law judge corps of the areas in which improvement in decisionmaking and/or documentation is necessary. Information of this type will be made available to all ALJs via instructional and educational material.

B. Standards Governing Disability Adjudication

As indicated in Chapter III, a major finding of the initial review was that the standards for deciding disability claims are applied differently at the various levels of adjudication. SSA has concluded that a significant contributing factor to this difference is that administrative law judges base their decisions on their own individual interpretations of the statute, applicable regulations, and Social Security Rulings without benefit of the guidance and clarification provided in POMS, which is used by the prehearing level adjudicators. We are persuaded that all adjudicators must be provided, and

required to adhere to, a consistent set of adjudicatory standards. Another major finding of the initial review was that there are a number of specific concepts and adjudicatory areas in which agency policy needs to be clarified. The primary examples, based on the study data, are impairment severity, assessment of residual functional capacity, effect of pain on residual functional capacity, and the treatment of mental disorders, both singly and in combination with physical impairments.

SSA is in the process of establishing a consistent set of adjudicatory standards which reflect and provide binding agency policy in adjudicating cases, particularly in the difficult decisional areas noted above. Heretofore, a primary vehicle for disseminating SSA policy and agency interpretations of the regulations and statute has been the POMS. Social Security Rulings, which include Program Policy Statements, have been used primarily to illustrate the application of SSA's policy or interpretation in specific cases and to enunciate the agency's position in major policy areas. The POMS has been used to provide more specific guidance and instruction to all SSA adjudicative personnel except the administrative law judges and the Appeals Council.

SSA now recognizes that the inclusion of more specific instructional material in POMS issuances which are not binding on ALJs and the Appeals Council, has resulted in adjudicative practices by these two sets of adjudicators which differ in many respects from those followed by the targeted POMS audience, the DDSs. To overcome this problem, SSA intends to expand its use of Program Policy Statements (which become Social Security Rulings) to address policy and adjudicatory areas which we believe are the most troublesome in terms of consistent application. Moreover, appropriate POMS guidelines will be issued in a manner which will make them binding on all levels of adjudication. These guidelines will be disseminated to all levels of adjudication and will represent a single set of standards for all to follow. We expect these efforts to have three major results:

(1) The adjudicatory standards governing DDS and ALJ decisionmaking will be essentially the same.

(2) More detailed and clearer guidance will be provided to all decisionmakers.

(3) Greater consistency, both among the DDSs and among the ALJs, as well as between the several adjudicatory levels, will be achieved.

C. Training

In recent years, primarily as a result of budgetary and resource constraints, OHA's activity in the area of program training for ALJs and support staff has been quite limited. The major effort was directed toward training of new ALJs and field personnel; however, because of the pressing need to make these resources available for case processing as quickly as possible, the training courses were of relatively brief duration. Similarly, refresher training has not been regular or systematic.

In the past, much of the responsibility for training was vested in OHA's regional offices. To insure that training for field personnel is expanded and improved, OHA has established a special staff in its central office to develop new and expanded training programs for all OHA field personnel. This staff will be developing a more extensive initial training program for new ALJs, an expansion of the continuing judicial

education now provided to ALJs, and integrated training packages for ALJ support staff, particularly the staff that assists in case development and decision drafting.

A major focus of the new training process will be the areas of adjudicative differences identified in the initial review. The training will also constitute an additional mechanism for providing feedback to the ALJs regarding deficiencies identified through the ongoing review. Through its training initiatives, OHA expects to promote among ALJs and their support staffs a better understanding and application of both current and revised standards and procedures, resulting in greater consistency and accuracy in decisionmaking.

D. Other Initiatives at the Hearing Level

Although SSA believes that the major initiatives discussed previously will substantially narrow the differences which exist in the adjudicative approaches used at the prehearing and hearing levels, we are also undertaking other initiatives to address these problems through examination of, and changes in, several key aspects of the hearing level process.

The first of these initiatives to improve decisional quality at the hearing level is the elimination of the short format for fully favorable decisions. Effective January 1982, OHA will begin to discontinue use of preprinted fully favorable allowance decision forms which contain no statement of the basis for the allowance. A revised format has been developed for allowance decisions to ensure not only that they will contain a specific explanation of the reasons for the favorable conclusion, including a discussion of all relevant evidence, but also that they reflect adherence to the sequential evaluation process directed by the regulations. To facilitate use of the new decision form, the format incorporates standardized language with respect to issues, citation of applicable regulations, findings, and decisional paragraphs. It also provides for individualized discussion of and rationale for the conclusion reached. SSA expects that this initiative should eliminate the implicit incentive toward favorable decisions which many critics and observers believe has resulted from use of the short format.

The second initiative directed at improved decisional quality is the planned implementation during fiscal year 1982 of an experiment under which SSA will be a party in certain hearing proceedings. For selected hearing offices, an SSA employee will have responsibility for representing SSA's position during hearings for those claimants who are represented. The purpose of the experiment is to determine whether the participation of an agency representative in hearings could contribute toward improving the quality and timeliness of hearing decisions. SSA expects that the participation of the SSA representative in prehearing development and during the hearing itself will relieve some of the burden on the ALJ corps which has resulted from the large and growing number of hearing requests in recent years. Although the ALJ will in all cases have final responsibility for conducting the hearing and for assuring that a complete record of the case is developed, as well as for the final disposition, the SSA representative will play an active role in obtaining relevant evidence and in explaining to the ALJ and the claimant the basis for the prior unfavorable determination. The experiment will last about 9 months, following which the results will be evaluated to determine whether the quality and timeliness of the hearing process has been improved. The primary concern with respect to the quality of decisions will be whether decisional inconsistency among the ALJs is reduced.

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E. Initiatives to Improve DDS Performance

Both as a result of legislative mandate and of internal SSA initiatives, SSA has undertaken a number of programs and experiments designed to improve the accuracy and consistency of disability decisions made by the DDSs. Two of these activities are particularly worth noting: the program of preeffectuation review of DDS disability allowances required by the Social Security Disability Amendments of 1980 (P.L. 96-265); and the so-called DARE experiments initiated by SSA to test ways in which the DDS reconsideration process might be improved.

The Disability Amendments of 1980 require that SSA conduct a Federal review of certain proportions of favorable Social Security disability decisions made by DDSs before benefit payments begin. This preeffectuation review, in which incorrect decisions made by the DDS are reversed prior to notification of the claimant or payment of any benefits, is intended to promote the uniformity and accuracy of favorable disability decisions. The review applies to decisions made by the DDSs on initial claims, reconsiderations, and continuing disability investigations (reviews of the disability status of individuals currently receiving disability benefits).

SSA began the program of preeffectuation review in October 1980. Reviews were targeted on those types of allowances determined from available data to be most likely to be in error. Where such data were not available, cases were selected on a random basis. Through June 30, 1981, about 17.5 percent of State agency allowances were reviewed by SSA, and about 8.5 percent of the cases reviewed were returned to State agencies, either because the finding of disability was erroneous or because the finding was inadequately documented.

As a result of the initial operation of the preeffectuation review program, it became clear that special attention needed to be devoted to reconsideration cases. Reconsideration allowances had an error rate of 9 percent, as compared to a 3.1 percent error rate on initial DDS allowances. In order to deal with this problem, SSA in fiscal year 1982 initiated preeffectuation review of 100 percent of all allowances made at the reconsideration level. This 100 percent review should improve the accuracy and consistency of DDS reconsideration decisions and, in addition, provide data for more accurately targeting error-prone cases for review in later years.

SSA is also conducting three experiments to determine whether changes in procedures at the reconsideration level would result in different outcomes when cases move on to hearings. These so-called DARE experiments are being conducted in a number of States throughout the country. The experiments test the following changes which might be made in the reconsideration process:

DARE 1—Expanded Reconsideration Process

DARE 1, being conducted by DDSs in two States, tests singly and in combination three changes in the reconsideration process. The first change requires that the DDS secure more complete medical evidence, including a consultative examination when one had not been purchased earlier. The second change requires the DDS to provide a separate statement of residual functional capacity. The third requires that the DDS prepare a lengthy formal notice of the basis for decision. Each of these changes will provide more complete documentation of the basis for the reconsideration decision, and may result in more accurate and consistent decisions.

DARE 2—Informal Remand

DARE 2 is evaluating the effect of the DARE 1 procedures on disability claims which are denied at reconsideration and are then informally remanded to the DDS for further development following the claimant's request for an ALJ hearing. The purpose of DARE 2 is to evaluate the likely effect of these procedures if they are applied only to those cases going to hearing.

DARE 3—Face-to-Face Interviews at Reconsideration

The DARE 3 experiment is evaluating the effect at the reconsideration level of face-to-face contact between the disability applicant and the DDS decisionmaker or SSA district office interviewer. The test will also evaluate the effect of when the interview is held—early or late in the reconsideration process. The experiment is being conducted in four States, and should give an indication of the value and effect upon decisional accuracy of including face-to-face contact between the claimant and the adjudicator prior to a formal ALJ hearing.

SSA believes that the preeffectuation review, in combination with any changes at the reconsideration level which may be found appropriate as a result of the experience with the DARE experiments, will result in more accurate, consistent, and better-documented decisions by the DDSs. These improvements, in turn, should assist in improving decisional accuracy at the hearings level.

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In summary, SSA has undertaken a number of activities designed to respond to the problems identified through the initial review. The most significant are probably the ongoing review of ALJ decisions required by P.L. 96-265, and the initiation of changes required to ensure that all SSA disability decisionmakers are governed by the same standards. In addition to enabling SSA to correct erroneous decisions, the ongoing review will provide SSA with the ability to continuously monitor the disability adjudication process to ensure that the problems identified in the initial review are actually corrected and that any additional areas of weakness are identified and acted upon. These actions, in conjunction with the other initiatives discussed in this report, should greatly improve the accuracy and consistency of disability decisions made throughout the SSA adjudicative system.

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Technical Appendix

I. Overview

As described in the text of the report, the research plan involved an intensive multi-phased review of a randomly selected sample of allowances and denials rendered by administrative law judges (ALJs) on the issue of disability in Title II Disability Insurance (DI) and Title XVI Supplemental Security Income (SSI) claims. This review involved SSA Office of Assessment (OA) examiners, Office of Hearings and Appeals (OHA) analysts, administrative law judges, the OHA Appeals Council, and the Office of Disability Programs' Medical Consultant Staff (MCS). The review was conducted in three phases, beginning in December 1980 and ending in July 1981.

Phase I was designed to determine the extent to which different standards applied by disability determination service (DDS) personnel and by ALJs affected hearing level reversal rates. It involved a basic sample of 3,600 recent cases which were reviewed independently by OA examiners, OHA analysts, the Appeals Council, and the Medical Consultant Staff.

Phase II focused on the effect upon ALJ decisions of the claimant's in-person appearance at a hearing. It required obtaining a second ALJ decision on 1,000 cases selected from the 3,600 base sample. The claimant's personal testimony was deleted from these 1,000 cases.

Phase III was designed to determine the effect of additional evidence submitted after the reconsideration determination. It involved the same 1,000 cases used in Phase II, except that all evidence added to the file after reconsideration was removed. Additional reviews of these cases were performed by a group of ALJs and OA examiners; the latter review included input from the MCS.

The sample selected for all phases of this study included only cases involving a primary applicant for disability benefits under DI and SSI. Therefore, claims involving disabled widows/widowers, disabled adult children, and health insurance or other non-disability cases were omitted. The cases were reviewed after the ALJ's original decision was effectuated; and the results of the reviews were not intended to have case-related impact. In other words, the claim was not "readjudicated."

II. Sample Design

A. Sampling Frame

The sample of ALJ decisions was drawn from lists of all allowances and denials for the months of September 1980 through January 1981 identified from OHA's management information system (MIS).

The sample included only cases involving a primary applicant for DI benefits or SSI payments. Disabled widow/widower, disabled adult child, and health insurance or other non-disability cases were not selected.

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B. Stratification

Cases listed for each month were stratified by three characteristics, which were used as the basis for sample selection.

1. Type of Claim

   a. Applicants for DI benefits, including those who applied concurrently for SSI disability payments

   b. Applicants for SSI disability payments only

2. Type of ALJ Decision

   a. Denial—Affirmation of State agency decision

   b. Allowance—Reversal of State agency decision

3. Allowance Rate of the Original ALJ During the Prior 6 Months

   a. High—71-100 percent

   b. Medium—56-70 percent

   c. Low—0-55 percent

The levels of ALJ allowance rates used for those three groupings were determined from the weighted distribution of ALJ allowance rates for claims adjudicated during the 6 month period ending September 30, 1980. The weight equaled the average monthly production rate of the individual ALJ during those 6 months. Three allowance rate levels divided that distribution into approximately three equal parts.

Use of these characteristics and their manipulation in the way described, resulted in 12 groups of strata. Table 1 presents the population of dispositions by stratum and month.

C. Phase I Sample

Original plans for the Phase I sample called for 400 completed cases from each of the 12 strata (4,800 cases in all) in order to insure reasonably precise contrast of estimated stratum allowance rates. Workload pressures in the field, however, necessitated reduction of the overall sample to 3,600 cases.

In order to achieve the latter figure, the number of sample cases required in the 6 denial strata was halved. A previous study 1/ had indicated that estimates of allowance rates for cases previously denied would be less variable than those for cases previously allowed.

1/ "Consistency of Initial Disability Decisions Among and Within States," SSA Publication No. 13-11869.

One third of the sample cases were allocated to the month of September (to facilitate the Phase II and III reviews). The rest of the sample cases were divided equally among the other 4 months. The number of sample cases drawn each month was 25 percent higher than the target sample size in anticipation that some cases would be out-of-scope for the review or not retrievable. Within each stratum for each month, simple random samples were drawn without replacement.

Although the initial selection process was designed to include only DI or SSI disability issue cases in the sampling frame, it turned out that a small proportion of "out-of-scope" cases were included in the frame and selected for the sample inadvertently. These cases generally involved non-disability issues and thus were subsequently excluded from the study and the analysis.

Also, due to the complex nature of the case handling process at the appellate level, a small proportion of the cases were irretrievable in the time period allocated for the study.

Table 2 presents by month and stratum, targeted sample sizes, sample sizes drawn, the total number of cases actually retrieved and percent of cases in-scope for the study.

D. Appeals Council Subsample

Original plans called for an Appeals Council review of the entire 3,600 case Phase I samples. However, lack of sufficient Appeals Council staff necessitated a reduction of the Appeals Council sample to about 2,000 cases.

The Appeals Council subsample included all cases where OA disagreed in Phase I with the original ALJ decisions and a random sample of one-sixth of the claims where OA agreed with the original ALJ decision. Table 3 shows the sample sizes obtained for the Appeals Council subsample.

E. Phase II/Phase III Subsample

In order to complete the field work for Phases II and III as quickly as possible, sample cases for these phases were drawn from September dispositions only. All September allowances and half of the cases from the September denial stratum were used. Of the targeted 1,000 cases for this subsample, 973 cases were completed for all of the Phase II and Phase III review processes.

III. Selection of ALJs for Phases II and III

Two separate samples of 48 ALJs were randomly selected, one for each of Phases II and III. Sample ALJs were identified from a roster of ALJs stratified by allowance rate into three equal groups based on experience for the 6-month period ending September 1, 1980. Each sample of 48 was composed of 16 ALJs from each of the high (68-100 percent), medium (55-67 percent), and low (0-54 percent) allowance rate levels. In those instances where an ALJ was unable to participate, a replacement was assigned from the same stratum.

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IV. Review Procedures

A. Folder Preparation

1. Lists of sample cases were prepared indicating whether the case was a DI (including concurrent DI/SSI) or SSI claim, an allowance or denial, and giving the current location of the claim folder. Sample case folders were retrieved and associated with the cassette recording of the hearing if a hearing had been held.

2. The original hearing decision was separated from the rest of the material and placed in a sealed envelope.

3. If the case was designated for use in Phases II and III of the study, the evidence in the folder was separated into three parts:

   a. All of the evidence considered in connection with the reconsideration determination was placed in one section.

   b. All additional evidence considered by the ALJ with a date of origin before the date of the reconsideration, and received after the reconsideration determination, was placed in a second section.

   c. All of the remaining evidence received after reconsideration was placed in a third section.

B. Phase I Review Procedures

1. Office of Assessment

   The first review was done by the Medical Consultant Staff and OA examiners, using the rules governing the DDSs and without knowledge of the original ALJ decision.

   a. Medical Consultant Staff—MCS performed a front-end review of all 3,600 cases in the baseline sample. A severity rating was made on each case based upon the total evidence in file. Cassette recordings of the hearing (if held) were considered as part of the evidence. The tape was audited to determine if there was medical or vocational specialist testimony at the hearing. The tape was flagged for MCS if it contained testimony from a medical specialist. Otherwise, the tape was audited at the discretion of the reviewer.

   Two additional ratings were made at the same time on cases to be included in Phase III of the study. The folders requiring additional ratings had the evidence divided into three sections as described above. Medical evaluation progressed from the first section (reconsideration evidence only) to the third (all evidence) with a separate evaluation form being filled out as each section of additional evidence was added. Reports of residual functional capacity were also prepared for cases where the individual's impairment was significant but did not meet the level shown in the Medical Listings.

b. OA Examiner Review—The OA examiner was required to review the total evidence in file, including the evaluation made by MCS, and to decide whether that evidence supported an allowance or denial using the standards of evaluation set forth in the POMS. If the case was designated for Phase III, the examiner also made a decision of allowance or denial based on the evidence available at the time of reconsideration.

2. Appeals Council Review

A de novo decision was made by the Appeals Council for each assigned case to the Appeals Council subsample and a study questionnaire was completed by an OHA analyst for each Appeals Council decision.

C. Phase II ALJ Review Procedures

Since new hearings could not be held as part of the study, written transcripts were made from the cassettes for each of the Phase II cases. These transcripts were used as the source of the expert testimony which had been presented at the original hearing. However, any testimony by the claimant or observations about the claimant's personal appearance were edited out of the transcript by an OA examiner. The cases were distributed at random to the Phase II ALJs. A decision to allow or deny, based on the evidence in the file and the edited transcript, was made for each case.

D. Phase III ALJ Review

The folders with only that evidence which was present at the time of reconsideration were distributed at random to the Phase III ALJs. A decision to allow or deny based on this evidence was made for each case.

V. Estimation Procedures

A. Phase I Sample

As indicated previously, the study was based not on a simple random sample, but rather on a stratified random sample with unequal sampling rates. As a result, estimates for the population of claims represented by the study sample could not be derived simply by inflating the sample results. Instead, case weights were constructed for each stratum separately to account for the unequal sampling rates and the cases which were out-of-scope or which could not be retrieved. A stratified ratio estimation technique was then used to make population estimates.

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Case weights were constructed using the following formula. The weight W_{hm} for the mth month and the hth stratum is given by:

$$W_{hm} = (N_{hm} \times P_{hm}) / n_{hm}$$

where

N_{hm} is the population for the h stratum in the mth month.

P_{hm} is the estimated proportion of in-scope cases in the hth stratum for the mth month.

n_{hm} is the number of completed sample cases in the hth stratum for the mth month.

The estimator of the in-scope population value for a characteristic, y, from the Phase I sample takes the form:

$$y = \sum_{h=1}^{12} \sum_{m=1}^{5} \sum_{i=1}^{n_{hm}} W_{hm} Y_{hmi} \qquad (1)$$

where

y_{hmi} is the value of the characteristic for the ith case in the mth month, in hth stratum.

The last column of Table 2 shows the stratum weights for the Phase I sample.

B. Appeals Council Sample

The estimator for the Appeals Council sample takes the same form as equation (1) above with an adjustment for the case weights to account for the subsampling of agreement cases previously described and to bring stratum estimates up to stratum population totals.

The Appeals Council weights were constructed as follows:

$$W_{hm}^{(AC)} = \begin{cases} \dfrac{n_{hm}}{(n_{hmd} + n_{hma})} \cdot W_{hm} & \text{for disagreements} \\ \dfrac{n_{hm}}{(n_{hmd} + 6\, n_{hma})} \cdot W_{hm} \cdot 6 & \text{for agreements} \end{cases}$$

where

n_{hm} and W_{hm} are defined as above.

n_{hmd} and n_{hma} represent the number of sample disagreements and agreements between OA and the original decision.

C. Phases II and III Sample

The estimator for this sample takes the same form as equation (1) above except that the weight W_{hm} is doubled for the denial strata (h=1, ..., 6).

VI. Estimation of Sampling Variances and Covariances

The variance estimator was derived by dividing each stratum into 10 random groups using the terminal digit of the case Social Security number. Variances and covariances were derived using the standard stratified random group estimator.

Standard error information is given in Table 4. Two words of caution are in order. First, the estimates of standard error for the Appeals Council sample are overestimated (that is conservative). 2/ Second, when making contrasts of percentages between decisionmakers on the same sample or between phases for the same decisionmaker, there are large positive sampling covariances between the estimates. Thus, the square root of the sum of the squares of the standard error for the two estimates would overestimate the standard error of the difference of the estimates.

2/ A generalized attribute curve did not fit well to the individual relvariances for the Appeals Council subsample.

TABLE 1.--Population totals--stratum by month

Stratum				Month				
Original decision	Type of claim	ALJ allowance rate	Total	Sept.	Oct.	Nov.	Dec.	Jan.
Total			80,783	17,502	17,268	16,265	14,966	14,782
1. Denial	DI	Low	10,527	2,349	2,313	2,062	1,809	1,994
2. Denial	DI	Medium	8,559	1,790	1,800	1,655	1,629	1,685
3. Denial	DI	High	3,131	658	700	624	591	558
4. Denial	SSI	Low	3,502	742	766	728	651	615
5. Denial	SSI	Medium	2,798	563	571	549	502	613
6. Denial	SSI	High	3,843	208	227	211	198	201
7. Allowance	DI	Low	10,661	2,331	2,291	2,191	1,944	1,904
8. Allowance	DI	Medium	16,514	3,470	3,467	3,298	3,097	3,182
9. Allowance	DI	High	13,993	3,212	3,000	2,847	2,680	2,254
10. Allowance	SSI	Low	2,776	576	595	581	517	507
11. Allowance	SSI	Medium	4,000	827	814	834	777	748
12. Allowance	SSI	High	3,331	776	724	685	571	575

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TABLE 2.--Completion rates for the phase 1 sample

Strata	Month	Target	Number of sample cases	Phase 1 sample: Number cases retrieved: Total	Phase 1 sample: Number cases retrieved: Percent inscope	Phase 1 inscope case weights
1	Total.....	200	252			
	September..		83	76	90	31
	October....		42	37	95	61
	November...		42	34	91	61
	December...		42	38	92	48
	January....		42	37	89	54
2	Total.....	200	252			
	September..		83	77	94	23
	October....		42	35	97	51
	November...		42	35	94	47
	December...		42	39	93	42
	January....		42	39	95	43
3	Total.....	200	252			
	September..		83	77	87	8
	October....		42	35	94	20
	November...		42	38	95	16
	December...		42	38	90	16
	January....		42	37	95	16
4	Total.....	200	252			
	September..		83	79	87	10
	October....		42	35	86	22
	November...		42	37	73	20
	December...		42	38	90	17
	January....		42	39	80	16
5	Total.....	200	252			
	September..		83	80	88	7
	October....		42	34	82	17
	November...		42	34	82	14
	December...		42	38	71	13
	January....		42	39	92	16
6	Total.....	200	252			
	September..		83	82	79	3
	October....		42	32	84	7
	November...		42	32	66	7
	December...		42	37	78	5
	January....		42	39	85	5
7	Total.....	400	499			
	September..		167	151	97	15
	October....		83	76	99	31
	November...		83	76	57	29
	December...		83	76	100	26
	January. ..		83	75	99	25
8	Total.....	400	499			
	September..		167	145	98	24
	October....		83	80	100	43
	November...		83	71	99	46
	December...		83	72	100	43
	January....		83	73	100	44

TABLE 2.--Completion rates for the phase I sample--continued

Strata	Month	Target	Number of sample cases	Phase I sample		Inscope case weights
				Number of cases retrieved		
				Total	Percent inscope	
9	Total.....	400	499			
	September..		167	155	98	21
	October....		83	74	97	40
	November...		83	63	95	39
	December...		83	73	99	36
	January....		83	74	99	30
10	Total.....	400	499			
	September..		167	131	80	4
	October....		83	67	94	9
	November...		83	57	84	10
	December...		83	70	89	7
	January....		83	71	90	7
11	Total.....	400	499			
	September..		167	148	87	6
	October....		83	69	83	12
	November...		83	64	91	13
	December...		83	70	81	11
	January....		83	76	86	10
12	Total.....	400	499			
	September..		167	135	83	6
	October....		83	68	91	11
	November...		83	59	92	12
	December...		83	75	84	8
	January....		83	74	80	8

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TABLE 3.--Appeals council subsample counts

	Total	Appeals council decision obtained	Appeals council decision not obtained
Total.....	3,558	2,183	1,375
OA agreed.....	1,579	255	1,324
OA disagreed.....	1,979	1,928	51

TABLE 4.--Standard error tables

A. Phase I sample

Base of percent	Standard error on estimated percent						
	5 or 95	10 or 90	15 or 85	20 or 80	30 or 70	40 or 60	50
2,500	2.2	3.1	3.7	4.2	4.8	5.2	5.3
5,000	1.6	2.2	2.7	3.0	3.5	3.7	3.8
7,500	1.3	1.8	2.2	2.5	2.9	3.1	3.2
10,000	1.1	1.6	1.9	2.2	2.5	2.7	2.8
25,000	.7	1.0	1.3	1.4	1.7	1.8	1.8
50,000	.5	.8	.9	1.0	1.2	1.3	1.4
75,000	.5	.6	.8	.9	1.0	1.1	1.2

B.--Appeals Council subsample

2,500	3.0	4.6	5.7	6.7	8.1	8.9	9.4
5,000	2.4	3.7	4.6	5.4	6.6	7.3	7.6
7,500	2.1	3.3	4.1	4.8	5.8	6.5	6.8
10,000	1.9	3.0	3.8	4.4	5.4	6.0	6.3
25,000	1.5	2.3	2.9	3.4	4.2	4.7	4.9
50,000 and over	1.2	1.9	2.4	2.8	3.5	3.9	4.1
and over	1.2	1.9	2.4	2.8	3.5	3.9	4.1

C.--Phase II/phase III subsample

2,500	1.9	2.7	3.2	3.7	4.3	4.6	4.8
5,000	1.4	2.0	2.4	2.7	3.2	3.4	3.6
7,500	1.2	1.7	2.0	2.3	2.7	2.9	3.0
10,000 and over	1.0	1.5	1.8	2.0	2.4	2.6	2.7

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2. The GAO Report, March 1981

BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

More Diligent Followup Needed To Weed Out Ineligible SSA Disability Beneficiaries

As much as $2 billion annually in Social Security disability insurance payments may go to individuals who are no longer disabled.

The Social Security Administration investigates only a small percentage of its disability program beneficiaries each year to determine whether they are still eligible. Individuals who are not investigated can, if they choose, continue to collect benefits until they voluntarily return to work, die, or reach retirement age. As many as 584,000 persons may not currently be disabled, but they may still be receiving disability benefits.

Although it may not be realistic to expect that all ineligible beneficiaries could be removed from the rolls, substantial savings would be achieved if Social Security stepped up its investigative efforts.

HRD-81-48
MARCH 3, 1981

96-297 O—82——1

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

MORE DILIGENT FOLLOWUP NEEDED TO WEED OUT INELIGIBLE SSA DISABILITY BENEFICIARIES

D I G E S T

The Social Security Administration (SSA) has not adequately followed up on Disability Insurance beneficiaries to verify that they remain disabled. It has limited its reviews--referred to as Continuing Disability Investigations (CDIs)--to a small percentage of beneficiaries. Most never have their eligibility reviewed and can remain on the rolls until they voluntarily return to work, reach age 65, or die. (See pp. 5 and 6.)

Even beneficiaries who met the criteria for reexamination have not always been investigated. Some were never scheduled for reexamination; others were scheduled but never reexamined. For example, in a 14-percent sample of all disability awards in 1975, 52 percent of the scheduled medical reexaminations were never done. GAO estimates that from that year alone there could be from 5,770 to 12,630 ineligible beneficiaries who are still on the rolls because scheduled reexaminations were not performed. (See p. 14.)

As a result of SSA's limited followup activity and poor management of the CDI process, as many as 584,000 beneficiaries who do not currently meet SSA's eligibility criteria may be receiving disability benefits. These beneficiaries represent over $2 billion annually in Trust Fund costs. Since SSA decisions on the continued eligibility of Disability Insurance beneficiaries are subject to appeal, it may not be realistic to expect that all these beneficiaries would be removed from the rolls. However, substantial savings could be achieved if SSA focused on this problem. (See pp. 7 and 8.)

Furthermore, inefficiencies in SSA's disability investigation program often result in program overpayments. In 1979, problems related to the investigation process contributed to about $77 million in overpayments, or about 44 percent of all Disability Insurance program overpayments for that year. (See p. 13.)

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Realizing that it has not adequately monitored the disability rolls, SSA plans to begin identifying persons not currently disabled and to better manage the investigation process to reduce the number of persons not disabled who are still receiving benefits. In addition, legislation passed in 1980 will require SSA, beginning in January 1982, to review the eligibility of every beneficiary at least every 3 years, unless the State examiner determines that the beneficiary is permanently disabled.

Although these are needed actions, GAO questions whether SSA is moving quickly enough and devoting enough resources to purge the Disability Insurance rolls.

In the past 2 years, SSA has concentrated on reexamining Supplemental Security Income disability cases that were converted in 1974 from the States to SSA. However, the magnitude of the Disability Insurance problem and the greater savings from correcting it now require that SSA give more priority to reevaluating this caseload. Because of limited resources, this may mean postponing further review of Supplemental Security Income conversion cases.

Accordingly, GAO recommends that SSA direct all of its additional $42 million fiscal year 1981 funds for continuing disability investigations to remove the nondisabled from the Disability Insurance rolls, and direct future budget outlays to the Disability Insurance rolls until the problem is under control. (See p. 11.) GAO also recommends other actions to improve the overall management of the CDI process. (See pp. 22 and 23.)

AGENCY COMMENTS

SSA agreed that additional efforts are needed to review disability cases and has begun to focus on high-risk cases. However, SSA continues to budget most of its limited resources on Supplemental Security Income disability cases. (See p. 11.)

SSA also said it plans to take the necessary corrective actions to improve the management of the CDI process. (See p. 23.)

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ABBREVIATIONS

ACID	Automated Continuing Investigation of Disability
CDI	Continued Disability Investigation
DI	Disability Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
HHS	Department of Health and Human Services
MBR	Master Beneficiary Record
SSA	Social Security Administration
SSI	Supplemental Security Income

CHAPTER 1

INTRODUCTION

The Social Security Administration (SSA) administers two benefit programs for disabled persons. SSA's Disability Insurance (DI) program was established in 1954 under title II of the Social Security Act to prevent the erosion of retirement benefits of wage earners who become disabled and are prevented from continuing payments into their social security account. In 1956 the program was expanded to authorize cash benefit payments to the disabled.

Title XVI of the Social Security Act established the Supplemental Security Income (SSI) program to provide cash assistance to needy aged, blind, and disabled persons. Effective January 1, 1974, the program replaced the former federally assisted, State-administered programs of Old-Age Assistance, Aid to the Blind, and Aid to the Permanently and Totally Disabled.

To be eligible for DI benefits, a worker must be fully insured for social security retirement purposes and generally have at least 20 quarters of coverage during the 40-quarter period ending with the quarter in which the disability began. The Congress established a separate Disability Insurance Trust Fund to specifically identify the costs of the DI program. All disability insurance benefit payments and associated administrative costs are disbursed from this fund. The DI benefit structure is the same as that used in SSA's Retirement Insurance program.

Eligibility under the SSI program is limited by income and resources. The limits vary by marital status and living arrangements. The SSI program is financed from Federal general revenues and is intended to provide a minimum income for eligible recipients. States can supplement Federal SSI benefits with their own funds.

The statutory definition of disability under the DI and SSI programs is substantially the same. Disability is defined as the inability to engage in any substantial gainful activity because of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months. Substantial gainful activity is any level of work performed for remuneration or profit that involves significant physical or mental duties, or both. Work may be considered substantial even if it is performed part time and is less demanding, less responsible, or pays less than the individual's former work.

A claimant can apply for disability benefits at any SSA district or branch office. Applications are processed by claims representatives, who interview the applicant and prepare disability and vocational reports for use by State agencies, which carry out

the disability determination process under agreements with the Department of Health and Human Services (HHS).

The State agencies' primary function is to develop medical, vocational, and other necessary evidence; evaluate the evidence; and make a determination as to the applicant's disability. The State agency uses the disability and vocational report prepared by the SSA district or branch office to determine what additional information must be obtained to fully develop a claim so that a decision can be made.

The criteria used for making the disability determination and the guidelines for developing and processing claims are furnished to the State agency by SSA. The Federal Government bears the costs incurred by the State agencies in making disability determinations.

Over the past several years, both programs have grown considerably. Between fiscal years 1972 and 1979, the number of beneficiaries increased from 3.3 million to 7.2 million and benefits paid increased from $4.0 billion to $17.9 billion. During this period, the cost of program administration by State agencies increased from $68.2 million to $311 million and the number of State employees increased from 4,400 to 9,600.

Disability Programs Benefits Paid

Fiscal year	Beneficiaries (end of year) (note a) Title II	Title XVI	DI Trust Fund	SSI general revenue	Total	Program administration by State agencies Cost	Employees
	(millions)		(billions)			(millions)	(thousands)
1972	3.3	-	$ 4.0	$ -	$ 4.0	$ 68.2	4.4
1973	3.6	-	5.2	-	5.2	80.4	6.3
b/1974	3.9	1.7	6.2	1.8	8.0	146.8	10.3
1975	4.4	2.0	7.6	3.0	10.6	206.8	10.1
1976	4.6	2.1	9.2	3.4	12.6	228.3	9.3
1977	4.9	2.2	11.1	3.7	14.8	254.2	9.4
1978	4.9	2.2	12.3	4.1	16.4	280.0	9.6
1979 (est.)	4.9	2.3	13.6	4.3	17.9	311.0	9.6

a/Figures for title II include disabled workers and their dependents. The number of primary disabled workers for 1979 was 2.9 million.

b/Payment of SSI benefits started in January 1974.

Beneficiaries can be terminated from the DI program because of

--attainment of age 65, at which time they are put on the retirement insurance benefit roll;

--death;

--medical recovery; or

--demonstrated ability to engage in substantial gainful activity.

This report discusses the latter two events and SSA's process for dealing with them.

THE CONTINUING DISABILITY INVESTIGATION PROCESS

The Continuing Disability Investigation (CDI) process is SSA's way of identifying beneficiaries who may have medically recovered or regained the ability to work and assessing their continuing eligibility for disability benefits.

Continuing medical eligibility is evaluated through the medical reexamination diary process. Since eligibility for SSA's disability programs is not necessarily based on permanent impairments, SSA has identified 17 conditions--such as tuberculosis, fractures, and infections--that have the greatest potential for medical improvement. (See app. I.) At the time of the initial disability determination, State agencies establish a future medical reexamination date ("diary") for beneficiaries with 1 of the 17 conditions. When the diaries mature, State agencies are to reevaluate beneficiaries' medical condition.

A CDI is also done when SSA learns that a beneficiary has returned to work. A beneficiary's return to work may indicate that the impairment has improved or that the individual has the capacity to work despite the impairment.

In 1978 SSA did CDIs on about 141,256 of the 2.9 million disabled workers on the DI rolls and terminated benefits in 72,606 (51.4 percent) of the cases reviewed.

OBJECTIVE, SCOPE, AND METHODOLOGY

In an April 18, 1878, letter to the Secretary of Health, Education, and Welfare (HEW), 1/ we reported that there was a

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1/Since May 4, 1980, HEW activities discussed in this report are the responsibility of HHS.

serious weakness in the administration of the disability aspects of the SSI program which allows medically ineligible recipients to go undetected. This earlier review did not look at the eligibility of DI beneficiaries.

In this report, we focus primarily on SSA's efforts to review the continuing eligibility of DI beneficiaries. We also address SSA's actions to correct the deficiencies noted in the April 18, 1978, report. We reviewed program policies and procedures, reports, and studies at SSA headquarters in Baltimore, Maryland. In addition, to gain a better understanding of the CDI process and the role of various components involved, we visited an SSA district office in Cincinnati; the SSA regional office in Philadelphia; the SSA Technical Assistance Section in Philadelphia; and the State Disability Determination unit in Columbus, Ohio.

According to 1977 and 1978 SSA work group reports, delays in completing CDIs and terminating benefits timely were major causes of overpayments in the DI program. To better understand the problems SSA was having with the CDI process, we selected a random sample of 120 cases with overpayments resulting from the process to determine if the problems still existed and whether corrective actions were needed. The sample was drawn from a universe of 754 overpayment cases where the disabled workers' social security numbers originated in Kentucky, Maryland, or Ohio, and the overpayment was identified by SSA from January 1, 1979, to September 27, 1979. SSA was able to locate and give us 49 case files of the cases selected.

Because one of the key features of the CDI process is the medical reexamination, we attempted to determine if all scheduled medical reexaminations were being done. To do so, we matched SSA's 1975 Continuous Disability History Sample file, which contains data on a sample of beneficiaries entering the DI rolls--including scheduled medical reexaminations--to a record of CDIs performed and their outcome. SSA refers to the latter record as the "833" file, and the record is current through the third quarter of fiscal year 1979. We also matched the social security number of beneficiaries who were scheduled for a medical reexamination with the Master Beneficiary Record (MBR) to determine how many were in current pay status. Because medical CDIs involve temporary type disabilities, about one-half of the beneficiaries should have medically recovered and been terminated from the DI benefit rolls.

96-297 O—82——14

CHAPTER 2

SSA NEEDS TO FOLLOW UP ON DISABILITY BENEFICIARIES TO DETERMINE THEIR CONTINUED ELIGIBILITY

Based on a nationwide sample case review recently conducted by SSA, we estimate that the Trust Fund could be losing over $2 billion a year because as many as 584,000 persons currently collecting disability benefits--20 percent of the 2.9 million primary beneficiaries on the DI rolls--may not meet SSA's current eligibility criteria. Most of them would not be subject to any followup reexamination or reevaluation and can, if they choose, continue to collect benefits until they voluntarily return to work, die, or reach retirement age. This condition exists because, annually, SSA investigates the eligibility of only a small percentage of DI beneficiaries. The majority of beneficiaries on the rolls (about 80 percent) are never reevaluated.

Because of concern expressed by congressional committees and us, SSA now recognizes that its followup on DI beneficiaries has been inadequate. This condition was further reinforced with SSA's meetings with private insurance industry representatives who advised SSA that the only way to manage a disability program is by frequently contacting beneficiaries and verifying that they remain disabled. SSA has taken steps which should prevent the future buildup of ineligible persons on the DI rolls. SSA must give more priority to identifying the nondisabled currently on the rolls and terminating their benefits.

SSA HAS NOT ADEQUATELY REVIEWED THE DI CASELOAD

SSA has placed little emphasis on reviewing the eligibility of beneficiaries once they are on DI rolls. As shown in the following table, only a small percentage of the disabled workers on the rolls are given a medical reexamination each year. This percentage ranged from 3.0 in 1973 to 3.6 in 1978, except in 1974 when SSA reexamined only 1.5 percent on the rolls. The advent of the SSI program in 1974 created a large workload pressure causing medical reexaminations to be lower that year.

Calendar year	Disabled workers on rolls at beginning of year	Medical reexaminations done	Percent of disabled workers reexamined	Work activity and other eligibility investigations	Percent of disabled workers investigated
1973	1,833,000	60,600	3.3	34,300	1.9
1974	2,017,000	30,200	1.5	35,400	1.8
1975	2,237,000	81,400	3.6	37,800	1.7
1976	2,489,000	75,000	3.0	37,200	1.5
1977	2,670,000	89,200	3.3	37,300	1.4
1978	2,834,000	100,211	3.5	41,045	1.4

Most beneficiaries never have their impairments reevaluated after initial eligibility is established. This may be the result of the wording in the Social Security Claims Manual, which cautions State agencies that most allowed cases involve chronic, static, or progressive impairments, subject to little or no medical improvement. Further, the manual states that in other cases, even though some improvment may be expected, "the likelihood of finding objective medical evidence of recovery has been shown by case experience to be so remote as not to justify establishing a medical reexamination diary." State agencies are instructed to schedule medical reexaminations only if the impairment is 1 of the 17 specifically listed. Historically, the percentage of new awards diaried has been small. From 1973 to 1977, only 18 to 26 percent of initial awards were scheduled for medical reexaminations. This means from 74 to 82 percent of the workers who came on the rolls during that period would probably never have been reevaluated--unless they returned to work and SSA became aware of the work activity.

According to SSA officials, this limited followup activity is due, in part, to the philosophy that has existed in SSA. When the DI program authorized benefits in 1956, the definition of disability was very restrictive and specified that the impairment had to be total and permanent or expected to result in death. Therefore, the DI program was patterned similar to SSA's retirement program and the emphasis was on paying benefits. In 1965 the definition of disability was liberalized to include persons with less permanent impairments--expected to last at least 12 months. However, SSA management did not put added emphasis on followup activity.

Surveys find many not disabled

In the past 2 years, studies of SSA's disability programs concluded that many beneficiaries may not currently be disabled.

Our April report 1/ to the Secretary of HEW was the first to show that a serious problem existed. We found that at least 24 percent of 402 SSI cases converted from the State disability programs and 10 percent of another 175 SSI cases were not disabled. The important point about these cases was that most (77 percent) of those found to be ineligible were not scheduled for a medical reexamination and probably would never have been detected by SSA.

Prompted by our report, in 1979 SSA reviewed a 5-percent sample of SSI conversion cases in the State of Washington and terminated benefits in 11.8 percent of the cases reviewed. SSA is now reviewing the remaining 7,600 Washington conversion cases. In addition, SSA took a nationwide sample of 13,000 conversion cases in March 1979 to determine which other States warrant a complete review. SSA expects the termination rate from this sample to be about 12.4 percent. SSA plans to review about 310,000 more conversion cases through fiscal year 1983.

Ineligibility in the DI program--a costly problem

Our April 1978 report did not address the DI program, but it did conclude that:

> "* * * the procedures for monitoring this program are similar to those used for the SSI program. Therefore, payments to beneficiaries who are no longer disabled could also occur under the DI program and go undetected."

SSA is finding this to be true, and it seems to be a more costly problem in the DI program than in the SSI program.

In July 1978 SSA began a review of DI cases which were not scheduled for a medical reexamination. Although this study was suspended after about 6 months to concentrate on the SSI conversion cases, SSA found that 11 percent of about 1,000 cases reviewed before the study's suspension were no longer eligible for DI benefits.

SSA has recently completed a comprehensive study of the DI rolls. This study--the Disability Insurance Pilot--was designed to test methods that SSA could use in an ongoing program for measuring DI payment accuracy. Through the Pilot, SSA also intended to develop indications of the major types and causes of payment error in the DI program.

SSA randomly selected 3,000 sample cases that were representative of the DI population, collected medical evidence, and in some cases visited beneficiaries in their homes to interview

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1/HRD-78-97.

them about their impairments. Using this evidence, SSA examiners and physicians determined that about 20 percent of the sample did not meet SSA's current eligibility criteria in the sample month, April 1979.

Based on this ineligibility rate, there could be about 584,000 persons on the DI rolls who may not meet the program's eligibility criteria. Since the Pilot study showed that the average monthly payment was about $350, SSA could be paying over $2 billion a year to persons not eligible for the program. This figure does not include the cost of Medicare benefits.

Although the Pilot study showed that 20 percent of the beneficiaries on the DI rolls are not disabled, the actual termination rate probably would not be that high. In some cases, while the State agencies might determine that the beneficiary is no longer disabled, the decision could be overturned through the appeals process. However, we believe the Pilot study is a good indicator--probably the best one available--that ineligibility in the DI program is a costly problem that must be corrected. For example, even if 10 percent of those on the rolls were ineligible and could be removed, the annual savings to the Trust Fund would amount to about $1 billion.

Several factors have contributed to the large number of nondisabled on the DI rolls. First, SSA believes that because of heavy workloads brought about by the SSI program and limited SSA quality assurance in 1974 and 1975, ineligible persons were erroneously placed on the rolls in these years. In addition, SSA had a policy in effect from 1969 until 1976 called the LaBonte principle (named after an administrative law judge's hearing decision) which stated that terminations had to be based on documentation which supported medical improvement. Under this principle, all initial disability decisions were presumed to be correct--even though this was not always true. As a result, when SSA discovered through medical reexamination that a person had been erroneously awarded DI benefits and was never disabled, the individual was allowed to remain on the rolls because there was no evidence of medical improvement. Finally, because SSA did not have an effective information system to enable it to manage the CDI process, many beneficiaries who met the diary criteria were never scheduled for a medical reexamination and many scheduled medical reexaminations were never done. (See ch. 3.)

SSA HAS INITIATED EFFORTS TO IDENTIFY THE NONDISABLED

As a result of our studies, SSA has concluded that to effectively manage a disability program it must frequently contact beneficiaries and verify that they remain disabled. Since 1979, SSA has acted to strenghthen the CDI process and prevent the future buildup of nondisabled on the DI rolls.

SSA plans to increase the number of medical reexaminations and improve their cost effectiveness. By better identifying the characteristics of workers likely to medically improve or otherwise be found ineligible, SSA hopes to increase the number of terminations resulting from medical reexaminations.

In an effort to reassess its guidelines for establishing medical diaries and increase the number of cases that are medically diaried, SSA began the Medical Reexamintion Improvement Test. This test gives the State agency professional staff the discretion to establish, in addition to the diary categories, a medical reexamination diary in any case where medical recovery appears likely. The test also raised questions about the adequacy of the current diary criteria, and SSA is making this option a permanent part of the program.

In fiscal year 1980, SSA began a review of 25,000 DI cases not currently scheduled for medical reexamination. Through this study, SSA intends to identify the characteristics of individuals most likely to be found ineligible. Such characteristics include the year of initial disability determination, the worker's age, impairment, and geographic location. The complete results of this study will not be available until spring 1981. SSA also planned to review 25,000 SSI conversion cases in fiscal year 1980. A total of $10.3 million has been budgeted for these two studies--$3 million for the DI probe and $7.3 million for the SSI effort.

SSA has budgeted $42 million for fiscal year 1981 to reevaluate an additional 100,000 SSI conversion cases. The cases reviewed may be a mix of DI and SSI cases, depending on the results of the 1980 probes. The supplemental funds will be used to purchase consultative medical examinations and to meet the additional personnel costs of the State agencies that arrange for the medical reexaminations to determine if the disability continues.

The Congress, also concerned about SSA's review of the DI caseload, passed legislation in 1980 that will result in SSA doing more continuing eligibility reviews. Unless the State agency examiner determines that the worker is permanently disabled, SSA must review the status of every beneficiary at least once every 3 years.

<u>SSA should give more priority to identifying the nondisabled on the DI rolls</u>

While SSA has taken steps to better manage the DI caseload, the question remains--can SSA move faster to identify the nondisabled currently on the DI rolls and prevent the annual loss of billions in Trust Fund money?

SSA plans to spend an additional $42 million in fiscal year 1981 for both the DI and SSI efforts. The SSA official responsible for improving the CDI process said that this was a realistic figure based on the State agencies' capabilities to hire, train, and house new employees. He said CDI cases are generally handled by the more experienced personnel in the State agencies, while the new examiners are trained to adjudicate initial claims. If new examiners are not properly trained, the quality of the initial decisions could decline, causing more nondisabled to come on the rolls. This happened in 1974 and 1975 when the SSI program began and is one cause of the current problem. He also said that many State agencies' facilities are already overcrowded and lack the space for many additional personnel.

With these limitations, SSA must decide how to best use its resources. In our opinion, SSA should give priority to purifying the DI rolls because of the potential savings involved. In the past 2 years, SSA has used most of its additional CDI resources on the SSI conversion caseload. Based on the results of the recently completed Pilot study, however, it would be more cost beneficial to concentrate future resources on the DI program. The average monthly benefit paid in SSI conversion cases is about $210 and in federally determined SSI cases about $148. In DI cases, the average benefit is about $397.

Furthermore, SSA is experiencing a high reversal rate in those SSI conversion cases where it terminated benefits. For example, the initial cessation rate in 10,450 cases reviewed from the nationwide conversion case study was about 27 percent (2,822 cases). However, 72 percent (2,032) of those with cessation decisions appealed, and about 63 percent (1,280) of those that appealed had the decision reversed. SSA officials stated that SSI recipients often have little or no work experience and many of those that are removed from the SSI rolls may begin receiving payments from other public assistance programs.

SSA will have enough information to effectively target the additional resources on the DI caseload in fiscal year 1981. Information should be available from the DI Pilot and the first increments of the 25,000 cases currently being probed. By matching the Initial Determination File and the CDI file, SSA can also identify beneficiaries who were scheduled for a medical reexamination but who were never reexamined. In addition, SSA knows that 1974 and 1975 were error-prone years. A review of cases placed on the rolls during those 2 years could also be fruitful.

Disability diagnosis not recorded on the MBR

SSA efforts to identify and remove nondisabled workers from the DI rolls will be impeded because the beneficiaries' disabling

SSA plans to increase the number of medical reexaminations and improve their cost effectiveness. By better identifying the characteristics of workers likely to medically improve or otherwise be found ineligible, SSA hopes to increase the number of terminations resulting from medical reexaminations.

In an effort to reassess its guidelines for establishing medical diaries and increase the number of cases that are medically diaried, SSA began the Medical Reexamintion Improvement Test. This test gives the State agency professional staff the discretion to establish, in addition to the diary categories, a medical reexamination diary in any case where medical recovery appears likely. The test also raised questions about the adequacy of the current diary criteria, and SSA is making this option a permanent part of the program.

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Disability diagnosis not recorded on the MBR

SSA efforts to identify and remove nondisabled workers from the DI rolls will be impeded because the beneficiaries' disabling

conditions are not recorded on the MBRs. Even though its ongoing studies may identify certain impairments that are likely to improve, SSA will have no way of knowing which beneficiaries have these impairments. The recording of disability diagnoses on the MBRs should improve the efficiency and effectiveness of SSA's efforts to target resources.

CONCLUSIONS AND RECOMMENDATIONS

SSA has not adequately monitored the disability rolls, but has initiated plans to increase the number and effectiveness of investigations. Because of the magnitude of the problem, delays in carrying out these plans could be costly. SSA should give higher priority to (1) identifying the nondisabled currently on the rolls and (2) improving the CDI process to prevent this number from increasing.

We recommend that the Secretary of HHS direct the Commissioner of Social Security to expedite efforts to reevaluate the DI rolls and to provide the necessary resources to support such efforts because of the potential savings. In this regard, SSA should use all of the additional $42 million fiscal year 1981 CDI funds to remove the nondisabled from the DI rolls and direct future budget outlays to the DI rolls until the problem is under control. To facilitate its current efforts and future management of the DI rolls, SSA should also begin coding the nature of the beneficiaries' impairments on the MBRs.

AGENCY COMMENTS AND OUR EVALUATION

SSA agrees that additional efforts are needed to review disability cases, and as we suggested, it has begun using available information to focus on high-risk title II cases. SSA is identifying high-risk cases and in the next few months expects to initiate investigations on 80,000 title II cases. In commenting on our report, SSA stated that:

> "We also concur with the present GAO report that from a cost-benefit perspective, it is wise to focus as quickly as possible on title II cases because the title II payment levels are higher."

Notwithstanding the above statement, SSA continues to budget its limited resources on SSI rather than title II case reviews--100,000 in each of fiscal years 1981 and 1982. This is not consistent with our recommendation and is not the most cost-effective use of limited SSA resources.

SSA also agrees that information concerning the nature of an individual's impairment should be retained, and it is exploring

methods, other than placing this information on the MBR as we recommended, that will give greater flexibility in selecting and managing this workload. SSA is conducting a staff analysis and is expecting a decision by early summer 1981. Since the beginning of the DI program in 1956, SSA has not coded the type of medical impairment on its MBRs, and even today it does not have a system to identify the impairments of the disabled population. Therefore, every effort should be made to obtain this information as soon as possible.

CHAPTER 3

SSA NEEDS A BETTER SYSTEM TO ASSURE THAT ELIGIBILITY REVIEWS ARE SCHEDULED AND PERFORMED

The medical reexamination diary process, which is SSA's primary means of identifying and investigating beneficiaries whose impairments are expected to improve, has not been effectively managed. As a result, even beneficiaries who met SSA's limited reexamination criteria were not always investigated--some were never scheduled for reexamination and others were scheduled but never reexamined.

These problems contribute to the loss of Trust Funds paid to the nondisabled. Missed medical reexaminations from 1 year alone may result in as much as $60 million annually in ineligible payments. Despite the severity of this situation, SSA has not given high priority to correcting it.

Furthermore, delays in completing investigations and terminating benefits when warranted, result in program overpayments. In calendar year 1979, problems related to the CDI process contributed to about $77 million in overpayments, or about 44 percent of all overpayments ($174 million) in the DI program for the year.

HOW MEDICAL REEXAMINATIONS ARE DONE

At the time of the initial disability determination, State agencies establish a future medical reexamination diary in cases where the beneficiary is expected to improve medically. The examiner records the scheduled reexamination date in the case folder and mails the folder through the district office to SSA headquarters. The diary date is then entered into SSA's Automated Continuing Investigation of Disability (ACID) system. Two months before the diary date, the ACID system flags the case. SSA headquarters personnel attempt to locate the case file and mail it to the State agency for investigation. Based on information provided by the beneficiary and current medical evidence, the State examiner determines if the disability still exists. The determination and folder are mailed back to SSA headquarters for review. SSA notifies the beneficiary of the results and terminates benefits if the disability has ceased.

In 1978, SSA made just over 100,000 medical reexaminations and terminated benefits in about 47,600 cases (47.5 percent).

Breakdowns in the medical reexamination process

The medical reexamination diary process has not worked as it should--many scheduled medical reexaminations are never done--because SSA did not have an effective management information system to monitor the process. SSA officials did not know the extent of this problem, but believed it was serious. We confirmed this belief.

In a 14-percent sample of all awards in 1975, 1/ 15,746 cases (18 percent of the sample) were scheduled for medical reexamination. Of this total, 8,254 (52 percent) were never done. Many of these beneficiaries (5,318) who were expected to medically recover but were never reexamined are still on the disability rolls. Based on the termination rate in medical reexamination cases in the last 4 years, there could be from 1,154 to 2,526 individuals who could receive from $5.5 million to $12.1 million in ineligible payments annually. Projecting these figures to the universe of all scheduled medical reexaminations for 1975, there could be from 5,770 to 12,630 beneficiaries who should not be on the rolls and who receive from $27.7 million to $60.6 million in ineligible payments annually.

Furthermore, when reexaminations are done, they are not always timely. One State agency study in 1979 demonstrated substantial delays in initiating continuing disability investigations in title II cases. According to this study, 48 percent (229 cases) arrived at the State agency after the scheduled reexamination date. Of these, 79 cases (about 34 percent) were 6 months or more after the diary date. In our limited review of 49 randomly selected overpayment cases, 25 had medical reexamination diaries scheduled. Thirteen of the 25 were sent to the State agency after the scheduled reexamination date. Most of the cases were 1 to 3 months late. In addition, four cases were never sent.

These problems exist because of a lack of effective internal controls over the process. SSA has no control mechanisms to ensure that all reexamination diaries are entered into the ACID system. In early 1978, SSA realized that district offices were failing to record the diary dates in a "significant number of cases."

Furthermore, even when the diary dates are entered into the system, SSA has not monitored the cases to ensure that the investigations are done and done timely. The monthly diary alerts are

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1/SSA's Continuous Disability History Sample is an annual sample of new applicants for DI benefits. The sample rate varies from year to year depending on the total number of workers allowed benefits.

individual pieces of paper, used only to locate and mail the cases. There are no consolidated lists of alerts generated monthly or lists of outstanding investigations showing age and location. The ACID system produces followup notices every 3 months after the initial alert until the investigation is completed. However, these notices--also individual sheets of paper--are not sent to the State agency that has the case, and SSA does not use them as a management tool. If the investigation is not completed and cleared from the system 12 months after it was due, the ACID system automatically destroys the record. When this happens, there is no evidence to show that a reexamination was ever scheduled.

Before the ACID system was implemented in October 1977, the situation was worse. Before that time, the CDI process was controlled by the MBR system. The MBR system erased the record of medical reexamination date at the same time it generated the alert that the reexamination was due.

There may be many beneficiaries who met the diary criteria, but who were never scheduled for a medical reexamination. For example, in 1973 only 18 percent of individuals receiving initial awards were scheduled for medical reexamination. Although the diary criteria remained the same, the rate rose to 26 percent by 1977. Fewer cases were diaried from 1973 to 1976 because of the emphasis on processing initial claims quickly. The CDI process was given low priority, and not all cases meeting the diary criteria were scheduled for reexamination--medical reexaminations were scheduled only in cases most likely to be terminated. During that period, SSA did not review State agency decisions to determine if all appropriate cases were diaried.

Medical reexamination process not likely to improve soon

In 1979, as a result of concerns expressed by the House Ways and Means Subcommittee on Social Security and our report (HRD-78-97), SSA recognized that its followup activity on DI beneficiaries was inadequate and that there were problems with the medical reexamination process. As discussed below, however, improvements to the process are not likely to be soon.

Management responsibility for the CDI process was given to the Office of Disability Programs in early 1979. This office is attempting to develop the management information necessary to manage the process. CDI program managers have requested that SSA data systems personnel make changes that will have the ACID system produce monthly, quarterly, and annual lists showing the number of outstanding investigations and their age and location. Lists showing all investigations that are 90 days or more overdue would be sent monthly to the SSA Regional Commissioners for followup action. The ACID system would be interfaced with SSA's Case Locator

System and followup notices sent directly to the field component processing the cases. The ACID system is to be reprogramed so that it will not erase the record of medical diary date after 12 months, as it now does. To help alleviate the problem of diaries not being entered into the ACID system, SSA had tested a procedure in May 1980 requiring all cases to have an entry in the MBR diary field--either the reexamination diary date or a code indicating that none was scheduled. National implementation of this procedure began in September 1980. SSA will also try to identify all cases where a medical reexamination was scheduled but never done.

However, actual implementation of most of these measures may take a long time. Because of other priorities within SSA, none of the planned improvements to the ACID system had been started as of February 1981, nor were there any plans to start them soon.

DELAYS IN WORK ACTIVITY INVESTIGATIONS CAUSE OVERPAYMENTS

SSA also does continuing disability investigations when it learns that beneficiaries have returned to work. This process, like that for investigating medical recovery, needs management attention. Delays in initiating and completing work activity investigations, and in terminating benefits when warranted, are creating large program overpayments.

A disability beneficiary's return to work may mean that eligibility has ceased. Therefore, SSA must evaluate the work activity in terms of duration, duties performed, and pay received, and it must determine if the beneficiary's impairment has improved or is less severe than alleged, or if the person is working despite the impairment. Generally, beneficiaries are given a 9-month "trial work period" to test their ability to work and hold a job. After the beneficiary has worked 9 months--not necessarily consecutively--SSA investigates the case to determine if the work continues and if it is "substantial gainful activity." SSA defines this activity as "performance of significant duties over a reasonable period of time for remuneration or profit (at or above $300 per month)." Eligibility ceases the first month the beneficiary engages in substantial gainful activity after completing the trial work period. Benefits, however, are paid during the 9 months of trial work, in the month eligibility ceases, and for 2 additional months--a total of 12 months.

SSA learns of work activity from several sources--the beneficiary reports from the States that an individual has completed a vocational rehabilitation program and was placed into competitive employment, social security earnings records, and third parties. Investigating work activity cases depends on when SSA learns the

beneficiary has returned to work. If information about a beneficiary's work activity is received before the individual completes the trial work period, SSA enters a diary date into the ACID system. The diary date is the month and year that the beneficiary is expected to complete the trial work period. The procedure from this point is similar to the medical reexamination process.

When SSA learns about a beneficiary's work activity after the trial work period has ended or in cases where the beneficiary was not entitled to one (i.e., the beneficiary previously used a 9-month trial work period), the diary process is not used. In these cases, the continuing disability investigation should be done immediately. In 1978, SSA made about 27,372 investigations involving work activity and terminated benefits in 17,682 cases (65 percent).

Problems causing delays in SSA's work investigation process

In both 1977 and 1978, SSA work groups looked into the problem of overpayments in social security programs. The work groups determined that inefficiencies in the CDI process were the primary cause of overpayments in the DI program and that one of the major problems was the difficulty in completing work investigations timely and terminating benefits when warranted. Thirty-four of the 49 overpayment cases reviewed were related to work activity investigations. Based on these cases and other documentation obtained during our review, it appears that the problem still exists and that delays are at least partially due to

--the complexity of an investigation process that involves various SSA components and the need to mail case folders between these components,

--lack of needed information at district offices concerning beneficiaries' work activity, and

--a lack of emphasis within SSA on terminating benefits.

Process is complex

SSA headquarters, district offices, and in some cases, State agencies play a role in work activity investigations, and cases are mailed back and forth between these components. The logistics of this process make it difficult to complete investigations timely. For example:

> A 56-year-old beneficiary with a statutory blindness disability and an undiagnosed disease returned to work in April 1977. SSA was notified of his return to work by a July 11, 1977, Vocational Rehabilitation completion report and an August 7, 1977,

self-report from the beneficiary. SSA headquarters requested the district office to investigate the case in December 1977--the final month of the trial work period. It took the district office until April 10, 1978, to complete the investigation. The district office found that the beneficiary had worked continuously and benefits should have been terminated a month earlier in March 1978. Because of an SSA policy concerning statutory blindness, only SSA headquarters can terminate benefits. The investigation materials and the case file were mailed separately to SSA headquarters.

On April 27, 1978, SSA mailed the case file back to the district office requesting another work activity investigation. The district office mailed the case back to SSA headquarters on May 10, 1978, noting that the original investigation material was mailed and another investigation would be a waste of time.

On June 7, 1978, SSA sent a third request for investigation to the district office stating that the original development materials had been lost. The district office completed the second investigation on October 25, 1978. SSA headquarters reviewed the case and determined that eligibility had ended. Benefits were terminated as of January 1979.

It took SSA over a year to complete this investigation and terminate benefits. Even though the beneficiary reported his work activity in a reasonable amount of time, he was required to repay $2,567.80 for overpayments received from April to December 1978.

The process is even more complex and the potential for overpayment is even greater when a beneficiary returns to work after unsuccessfully completing a prior trial work period or is not entitled to a trial work period. Such cases require an immediate investigation which SSA seldom accomplishes under the current system. For example:

A 27-year-old beneficiary with a disability of multiple fractures completed 9 months of trial work in November 1977. At that point his work was interrupted when he was hospitalized.

This individual returned to work in May 1978 and reported this to the district office on July 20, 1978. At that point, the district office had little time to take the necessary action to prevent the overpayment. The beneficiary's eligibility had

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ceased in May, the first month he engaged in substantial gainful activity after completing the trial work period. Accordingly, his benefits should have been terminated as of August 1978.

It took the district office from July 20, 1978 (when the beneficiary reported) to August 28, 1978, to record the beneficiary's work activity. Since the district office did not have the case folder, it was unaware that the trial work period had expired and mailed the information to SSA headquarters without suspending benefits.

Headquarters personnel reviewed the case on October 24, 1978, and even though the case had been in overpayment status since August 1978, they did not suspend benefits. Instead, the case was mailed back to the district office on October 30, 1978, for a complete investigation. The district office did not finish the investigation until January 10, 1979, and apparently by mistake, mailed the case to the State agency. The State agency forwarded the case to SSA headquarters on January 20, 1979.

SSA headquarters mailed the case back to the district office on February 20, 1979 (reason unknown), and benefits were finally terminated as of May 1, 1979.

Because it took SSA from July 1978 to May 1979 to terminate benefits, the beneficiary was charged with an overpayment of $3,637--even though the overpayment was caused primarily by SSA's delays.

District offices lack up-to-date information

One obstacle to terminating benefits promptly, as seen in the above-mentioned example, is the fact that district offices generally do not have the disability case folders or up-to-date information about beneficiaries' work activity during the disability period. Consequently, when the beneficiary reports work activity, the district office sometimes provides incorrect or misleading information about continued entitlement to benefits. Beneficiaries are confused and frustrated when this information is later contradicted by SSA headquarters, and they are required to repay benefits they were not entitled to.

SSA is failing to act quickly when information is available

Another problem causing overpayments is SSA's failure to act quickly to terminate benefits, even when an overpayment is obvious.

Several times in the above-mentioned example either the district office or SSA headquarters could have reduced the amount of the overpayment by terminating the benefits several months earlier. This problem can also be seen in the following example:

> A 42-year-old beneficiary with a disability of agitated depression returned to work in October 1977. The Vocational Rehabilitation Agency completed its report of this work activity on March 9, 1978, and it was received at SSA headquarters in August 1978.
>
> SSA headquarters mailed the beneficiary a questionnaire on September 28, 1978. The beneficiary completed the questionnaire on October 12, 1978, showing that she had engaged in substantial gainful activity since October 1977. Therefore, when SSA received this information the beneficiary had completed the trial work period (July 1978), eligibility had ceased in August, and payments should have stopped in October. However, rather than suspending benefits, SSA headquarters mailed the case to the district office on November 7, 1978, and the case resulted in a 1-month overpayment of $305.

SSA officials stated that the emphasis in the DI program has always been on paying benefits and terminating benefits has been the exception. One SSA official referred us to a statement in the Claims Manual as an illustration of this emphasis:

> "Request the suspension of disability benefits in work issue cases only when the evidence convincingly establishes a basis for cessation of benefits, an overpayment exists or is imminent, and the DO [District Office] expects the completion of the CDI to be delayed. Suspension of disability benefits (including auxiliary payments, if any) is to be processed only after advance notice (in person, by phone, or by mail) under due process procedures. The DO will notify the beneficiary and all auxiliary beneficiaries not living in the same household of any proposed action to suspend benefits before transmitting a suspension request to BDI [Bureau of Disability Investigations]. Do not suspend benefits if cessation is effective for the current month since the beneficiary is entitled to two additional months of benefits after the month of cessation. The DO will not use the suspension procedure when possible reentitlement after a work cessation exists." (Underscoring added.)

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In addition, SSA studies show that district office personnel do not always have a good working knowledge of the CDI process and benefit cessation procedures. According to one SSA official, because of the emphasis in SSA policies and the possible adverse reaction from beneficiaries, congressmen, and the press, district offices often refer cases to headquarters for final decision rather than initiating the action to terminate benefits.

To improve the CDI process and reduce program overpayments, SSA must identify and eliminate the delays in doing work activity investigations and terminating benefits. As part of the effort it may be necessary to revise the existing policy and reeducate agency personnel on the importance of terminating benefits promptly when termination is warranted.

Annual wage reporting--a setback to SSA enforcement efforts

Unfortunately, not all beneficiaries are conscientious and report to SSA when they return to work. Beneficiaries' failure to report their work activity was a contributing factor in 12 of the 34 work activity overpayment cases reviewed. SSA no longer has a backup method for detecting earnings when disability beneficiaries return to work but do not report their income.

Until 1978, SSA required that all employers with three or more employees report quarterly the amount paid to each worker. SSA posted the reported earnings to individual accounts and compiled a Summary Earnings Record for all employees. This record was interfaced with the MBR, enabling SSA to identify DI beneficiaries who had returned to work but had not reported their earnings. Generally, SSA learned about beneficiaries' earnings about 6 to 9 months after the work was done and initiated investigations when appropriate.

In 1978, legislation mandated SSA to change the wage reporting from quarterly to annually. Because of the additional delay in receiving wage information under annual reporting, use of this information to identify earnings and to terminate benefits will result in larger overpayments than the quarterly system. For example, because of this change and delays in making the necessary system changes to process the annual report, the 1978 earnings had not been posted to individual accounts as of May 1980. A beneficiary who returned to work in early 1978, but did not report earnings will have received ineligible payments for about 2 years by the time earnings are posted and SSA investigates.

To help reduce the overpayment problem caused by this change, SSA mailed disability beneficiaries notices in August 1978 and October 1979 reminding them to report work activity. SSA believes that, while these efforts were relatively successful, they do not replace the quarterly wage reports.

CONCLUSIONS AND RECOMMENDATIONS

SSA has not effectively managed the CDI process. Thus, even beneficiaries who met SSA's limited medical reexamination criteria were not always investigated--some were never scheduled for reexamination and others were scheduled but never reexamined. Furthermore, beneficiaries who returned to work were often paid benefits they were not entitled to because SSA was slow to investigate and terminate their benefits. Until these problems are corrected, the Trust Fund will continue to lose millions of dollars annually.

Accordingly, we recommend that the Secretary of HHS direct the Commissioner of Social Security to improve the management of the CDI process. Specifically, SSA should:

--Give priority to improving the ACID system so that management will have a comprehensive list of overdue investigations, their age, location, and status.

--Run the Initial Determination File ("831") against the CDI file ("833") to identify and reevaluate those cases where a medical reexamination was scheduled but not done.

--Emphasize the importance of the CDI process and SSA's current position for reviewing the disability caseload and terminating benefits for those no longer eligible, especially by (1) rewriting the section of the Disability Manual pertaining to continuing investigations and removing the restrictive language which may discourage SSA staff from terminating benefits and (2) providing training to district office personnel on the intent and mechanics of the CDI process.

--Improve the district office and State agency capability to do thorough, timely investigations and to terminate benefits when warranted. One such measure would be to provide work activity information on the MBR so the district office can access this information when a beneficiary reports that he or she has returned to work.

--Measure the impact of annual wage reporting on detecting program overpayments and, if warranted, devise alternative methods to identify beneficiaries who returned to work.

--Periodically review cases where overpayments were caused by the CDI process to identify and correct problems causing the overpayments.

We also recommend that the Secretary study the feasibility of storing certain disability cases--perhaps those with "profiles" that indicate potential for medical recovery or work activity--in the

district offices and assigning full responsibility for these cases to claims representatives. Although there would be additional personnel costs, the potential benefits to the disability program, considering that a beneficiary receives from $30,000 to $50,000 over his or her lifetime, should outweigh the costs. We believe the cost effectiveness of the case management approach in selected situations should be evaluated through a pilot test.

Many of the problems discussed in this report could potentially be eliminated by decentralizing case management responsibility to the district offices. The claims representatives in the district offices would be better versed in all aspects of the disability program and could better serve the beneficiary and the Government. Locating and mailing cases across the country would no longer be necessary. There would be a closer relationship between the beneficiary, the claims representative, and the local vocational rehabilitation counselor, thus helping the rehabilitation effort. In addition, the frequency of contact with the beneficiary would be increased, thus:

--Helping overcome the beneficiary's perception that disability benefits will continue permanently.

--Allowing SSA to become aware of the proce[illegible] changes affecting eligibility and payment status.

--Helping SSA meet the legislative requirements to review cases every 3 years.

In general, this decentralized case management could increase responsiveness to the beneficiary and allow SSA to better protect the integrity of the disability rolls.

AGENCY COMMENTS AND OUR EVALUATION

SSA generally agreed with most of our conclusions and recommendations, and plans to take the necessary corrective actions. (See app. II.) In a few cases, however, we believe SSA's comments deserve futher discussion.

Concerning our recommendation that SSA give priority to improving the ACID system, SSA agreed that ACID should be used to control CDI workloads, but is waiting for design modifications to the system. Because of the large sums being paid to potentially ineligible recipients, SSA should place high priority on developing and incorporating the necessary modifications to ACID.

Concerning our recommendation that SSA match the Initial Determination File against the CDI file to identify those cases where a medical reexamination was scheduled but not done, SSA

acknowledged that the CDI process resulted in "some" lost diaries and that better procedures are needed to obtain them. Our matching of the Initial Determination File and the CDI file clearly shows that the problem is more significant than implied by SSA's comment that only "some" diaries were lost. We projected that in 1975 alone 52 percent of the diaried cases were never done and as many as 12,630 beneficiaries could be receiving over $60 million in ineligible payments annually.

Also, SSA does not agree with the methodology we recommended to match the Initial Determination and CDI files because the (1) SSA CDI file does not contain concurrent DI/SSI cases and (2) medical reexamination diaries can be legitimately deleted through a process which does not use the SSA CDI form. SSA believes the best method to identify lost cases may be to match the Initial Determination tape with the MBR. Our recommendation to match these files would give SSA an immediate "high-hit" target group of potentially ineligible persons to investigate. While SSA's suggested methodology may ultimately be more thorough, we are concerned with the timeliness of its implementation. SSA began testing its methodology in April 1980, and as of February 1981, it was continuing its efforts without success.

In commenting on our recommendation to study the feasibility of using case management as a cost-effective approach for managing the DI rolls and returning beneficiaries to work, SSA agreed with the aim of our recommendation and acknowledged the need for improvement in overall case management so the CDIs could be conducted more efficiently. However, SSA expressed concern with maintaining individual case files at the district office level and said it is testing an alternative procedure--a folderless CDI process. If this is successful and the procedure is implemented nationwide, SSA believes the need for district office folder retention would be obviated.

We believe a folderless CDI process would be an improvement; however, our recommendation for testing the case management approach addresses more than the issue of where case files should be retained, it addresses the need for more information on beneficiaries at the district office level and a need for more contact with the disabled population. In other words, SSA should provide timely and continuous assistance to beneficiaries that have potential for medical recovery and for work activity.

SSA DIARY CATEGORIES (note a)

1. Tuberculosis--without pulmonary insufficiency or severe organ damage due to extrapulmonary disease.

2. Functional psychotic disorders where onset is established within the 2-year period preceding the State agency's determination of disability.

3. Functional nonpsychotic disorders.

4. Active rheumatoid arthritis without residual structural deformity.

5. Any case in which corrective surgery is contemplated or where adjudication takes place during the postsurgical convalescent period and recovery can be anticipated. This includes cases involving surgery for heart or kidney disease, nerve root compression, and lumbar (lumbosacral) fusion.

6. Obesity--in and of itself producing manifestations limiting work capacity.

7. Fracture(s) of any bone(s) without severe residual functional loss or structural deformity.

8. All infections.

9. Peripheral neuropathies.

10. Sarcoidosis without severe organ damage (e.g., pulmonary, ocular, renal, etc.).

11. Progressive neoplastic disease is highly probable, but full medical workup falls short of a definitive diagnosis.

12. Neoplastic disease which has been treated and incapacitating residuals exist, but improvement of these residuals is probable.

13. Epilepsy.

a/In December 1980 four new categories of impairments for reexamination have been added: respiratory disease based on frequency of acute episodes, acute leukemia, central nervous system trauma, and back conditions amenable to treatment.

APPENDIX II

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

13 FEB 1981

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Social Security Needs to Follow-Up on Disability Beneficiaries to Determine Their Continued Eligibility." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan B. Mitchell
Acting Inspector General

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED, "SOCIAL SECURITY NEEDS TO FOLLOW-UP ON DISABILITY BENEFICIARIES TO DETERMINE THEIR CONTINUED ELIGIBILITY"

General

We are in general agreement with GAO's findings, particularly with GAO's recognition that SSA was aware of many of the problems and has been moving to resolve them.

At the start of 1978, SSA's analyses began to produce trouble signals in the continuing disability programs. These signals were amplified by GAO's 1978 review of the continued medical eligibility of disabled Supplemental Security Income (SSI) recipients. (Some common processes characterize the SSI and the title II disability insurance (DI) programs insofar as continued medical eligibility is concerned.)

SSA management got a better fix on the range of these problems in 1979 and, in that year and 1980, took many steps--beginning some, and completing others--to deal with them.

We acknowledge that much remains to be done to correct this complex situation. SSA believes that the ultimate solution will be the implementation of the periodic review provision of P.L. 96-265--the Social Security Amendments of 1980--effective January 1, 1982. This provision requires that SSA review all "non-permanent" disabled beneficiaries at least once every three years. (Permanently disabled persons are also subject to review but not necessarily every three years).

Without waiting for January 1982, SSA has taken a number of steps to do additional continuing disability investigations (CDIs) to determine whether persons getting title II or title XVI benefits on the basis of a disability are still disabled.

--Completed early in 1980 a review of over 10,000 disability cases that were converted from the State assistance rolls to identify persons who are not disabled,

--Instituted in 1980 a national review (which will be completed by 3/31/81) of 25,000 title II disability cases designed to remove nondisabled people from the rolls and to identify types of beneficiaries most likely to be found ineligible,

--Budgeted in January 1980 to review 130,000 additional CDIs in FY 1981 (nearly doubling the number previously scheduled for review), thus increasing State agency staff to handle increased workloads. This will enable us to remove more ineligibles from the rolls and will enable us to build DDS capacity to handle the increased workloads arising from the periodic review mandate,

--Completed a review of 3000 current title II disabled beneficiaries to determine the DI payment error rate and to permit profiling of high-risk cases, and

--Developed and initiated systems changes to improve our efforts to maintain the integrity of the disability rolls.

We believe these steps, and many others described below, show that SSA is well out in front in dealing with the problems cited in the GAO report and in implementing the periodic review provision of the 1980 disability amendments.

GAO Recommendation

That the Secretary of HHS direct the Commissioner of SSA to expedite efforts to reevaluate the DI rolls and to provide the necessary resources to support such efforts. In this regard, SSA should use all of the additional $42 million fiscal year 1981 CDI funds to remove the nondisabled from the DI rolls. To facilitate its current efforts and future management of the DI rolls, SSA should also begin coding the nature of the beneficiaries' impairments on the Master Beneficiary Records(MBRs).

Department Comment

We recognized that additional efforts were needed to review disability cases, and initiated an expanded effort by budgeting to review the following additional disability cases:

	FY 1981	FY 1982
Title XVI (SSI) Conversion	100,000	100,000
Title II (DI)	30,000	210,000

We believe there is benefit to reviewing current SSI beneficiaries who were converted from the State to the Federal SSI program in 1974 to assure that they continue to be disabled--as GAO recommended in 1978. SSA has already identified over 50,000 SSI conversion cases for review. We also concur with the present GAO report that from a cost-benefit perspective, it is wise to focus as quickly as possible on title II cases because the title II payment levels are higher. To do this effectively we need to be able to identify high-dollar error title II cases. To that end SSA has recently developed profiles that can be used to identify high-dollar error title II cases. SSA is in the process of identifying cases that conform to these profiles and in the next few months expects to be in a position to initiate CDIs on 80,000 title II cases.

The level of effort devoted to continuing disability investigations and the distribution between title II and title XVI cases for 1981 and future years is presently being assessed as part of the Administration's budget review. Details will be forthcoming as part of the President's proposed budget modification for FY 1981 and 1982.

We also agree that information concerning the nature of an individual's impairment should be retained. We are exploring ways of doing this other than the method recommended. Some of these could provide the advantage of

greater flexibility in the selection and management of this workload than could the MBR. Staff analysis is underway which should permit a decision by early summer.

GAO Recommendation

That the Secretary of HHS direct the Commissioner of SSA to improve the management of the CDI process. Specifically, SSA should:

--Give priority to improving the Automated Continuing Investigation Diary System so that management will have a comprehensive listing of overdue investigations, their age, location, and status.

--Run the Initial Determination File ("831") against the CDI File ("833") to identify and reevaluate those cases where a medical reexamination was scheduled but not done.

--Emphasize the importance of the CDI process and the Administration's current position for reviewing the disability caseload and terminating benefits for those no longer eligible, especially by:

  --rewriting the section of the Disability Manual pertaining to continuing investigations and removing the restrictive language which may discourage SSA staff from terminating benefits, and

  --providing training to District Office personnel on the intent and mechanics of the CDI process.

--Improving the District Office and State agency capability to do thorough, timely investigations and to terminate benefits when warranted. One such measure would be to provide work activity information on the Master Beneficiary Record so the District Office can access this information when a beneficiary reports that he/she returned to work.

--Measure the impact of annual wage reporting on detecting program overpayments, and if warranted, devise alternative methods to identify those beneficiaries who returned to work.

--Periodically review cases where overpayments were caused by the CDI process to identify and correct problems causing the overpayments.

Department Comment

--We agree that the Automated Continuing Investigation Diary (ACID) system should and can be utilized to provide very important operational and management controls over the CDI workloads and it is being redesigned to do so. While waiting for systems modifications, we are exploring ways to collect and utilize the information manually. We expect the manual reports to be available and in use in the next few months. We have also begun on a manual basis the process of directing follow-up alerts to the cognizant work station in response to GAO's observation that follow-up alerts on delayed medical reexaminations were not reaching the staff responsible for scheduling them. This procedure will be automated at a later date.

--We acknowledge that in the past the continuing disability process resulted in some lost diaries, 1/ and better procedures are needed to recapture diaries that have been lost. However, we do not believe the methodology recommended by GAO is the answer since: (1) the SSA "833" file does not contain concurrent DI/SSI cases, and (2) the medical reexamination diaries can be legitimately deleted through a process which does not employ the SSA "833" form. We believe the best method to identify lost cases may be to match the "831" tape with the MBR. We are now refining our procedures.

As part of the refinement, we now require that every case have an entry in the medical diary field on the system prior to payment.

--Revised disability program instructions to improve the CDI process will be implemented in the spring. Training on the CDI process is expected to accompany issuance of these revised instructions to insure uniform implementation of the changes. We will also prepare material that emphasizes the Administration's policies and position on the CDI process and disseminate it to the field. This material will explain the intent and philosophy of the process so that field personnel will have sufficient support in interviewing beneficiaries and processing the CDI cases.

--Since September 1977, a full range of CDI-related data has been available on the MBR and its related systems. A trial work indicator is readily accessible to field and reviewing offices via the existing MBR query facility. Further queries will even provide the actual number of months of work activity. In addition, in November 1980, a pilot procedure was instituted which provides for direct DDS teletype of title II cessations to central office which result in immediate termination action being completed prior to the receipt of the folder in central office. National expansion of this pilot will be completed in early 1981.

--In order to measure the impact of annual wage reporting and as a possible source of current earnings information, we used mass mailings in 1978 and 1979 to solicit earnings information directly from the disabled beneficiary. Once the 1978 and 1979 data is processed for enforcement purposes, we will compare the information from the mass mailers to the annual wage data to determine the value of the mass mailers and the impact annual wage reporting has had on the CDI process.

--Review of the CDI process is ongoing with special emphasis on the cause of overpayments. Within the last 6 months alone we have altered the alert processes to speed up the conduct of CDIs, conducted a study designed to process CDIs without folders (earlier processing) and initiated the use of teletypes to assure the timely termination of benefits. Each of these actions is/was aimed specifically at reducing or eliminating overpayments or the causes of overpayments. It should be recognized that "due process" requirements do produce a certain amount of delay in effectuating terminations.

1/ The establishment of a reexamination date is called a "diary."

GAO Recommendation

That the Secretary study the feasibility of storing certain disability cases--perhaps those with "profiles" that indicate potential for medical recovery or potential for work activity--in the District Offices and assigning full responsibility for these cases to claims representatives.

Department Comment

We agree that improvements are needed in our overall case management so that continuing disability investigations will be conducted efficiently and on a timely basis. However, decentralization of folder maintenance to district offices as recommended by GAO has significant inherent problems because the folder must be available for other purposes than CDIs, such as payment processing. We believe the modularization of central disability operations, including control of folders, is a very positive step in bringing about improvements in case management. We are looking at other ways as well, including (1) conducting CDIs on a folderless basis, and (2) storing the medical portion of high risk folders in a field location.

Technical Comments

GAO note: SSA provided several technical comments which have been incorporated into the report.

(105075)

APPENDIX C: DISABILITY CLAIMS AND REVIEW REPORTS

96-297 O—82——16

1. Disability Report

Department of Health and Human Services
Social Security Administration

Form Approved
OMB No. 0960-0141

DISABILITY REPORT

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. **COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.**

Privacy Act Notice: The information requested on this form is authorized by Title 20 CFR 404.1523 and Title 20 CFR 416.923. The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to social security programs and to comply with Federal laws requiring the exchange of information between Social Security and another agency.

A. Name of Claimant	B. Social Security Number	C. Telephone number where you can be reached:
D. What is your illness or injury?		

PART I — INFORMATION ABOUT YOUR CONDITION

1. A. When did your illness or injury first bother you?	MONTH, DAY, YEAR
B. When did your illness or injury finally disable you?	MONTH, DAY, YEAR
C. Explain how your condition affects you and keeps you from working?	

2. Have you worked since the date shown in item 1A? *(If "No," go on to Part II)* ☐ Yes ☐ No

3. If you did work since the date in Item 1A did your condition cause you to change —

Your job or job duties?	☐ Yes	☐ No
Your hours of work?	☐ Yes	☐ No
Your attendance?	☐ Yes	☐ No
Anything else about your work?	☐ Yes	☐ No

(If you answered "No" to all of these, go on to Part II)

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4. If you answered "Yes" to Item 3, explain below what the changes in your work circumstances were, the dates they occurred, and how your condition made these changes necessary:

PART II — INFORMATION ABOUT YOUR MEDICAL RECORDS

5. A. Have you had any of the following tests in the last year:

Test	Check Appropriate Block or Blocks: Yes	No	If "Yes", show: Where Done	When Done
Electrocardiogram	☐	☐		
Chest X-ray	☐	☐		
Other X-ray (Name the body part here _____)	☐	☐		
Breathing Tests	☐	☐		
Blood Tests	☐	☐		
Other (Specify)	☐	☐		

B. If you have a Medicaid card, what is your number (some hospitals and clinics file your records by your medicaid number):

6. List the name, address and telephone number of the doctor who has your latest medical records. If you have no doctor, check here ☐

NAME

ADDRESS

AREA CODE AND TELEPHONE NUMBER

HOW OFTEN DO YOU SEE THIS DOCTOR?

DATE YOU FIRST SAW THIS DOCTOR

DATE YOU LAST SAW THIS DOCTOR

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED

7. A. Have you seen any other doctors since your illness or injury began? ..... ☐ Yes ☐ No
If "Yes," show the following:

NAME	ADDRESS
AREA CODE AND TELEPHONE NUMBER	

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR	DATE YOU LAST SAW THIS DOCTOR

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED

B. Identify below any other doctor you have seen since your illness or injury began.

NAME	ADDRESS
AREA CODE AND TELEPHONE NUMBER	

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE YOU FIRST SAW THIS DOCTOR	DATE YOU LAST SAW THIS DOCTOR

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED

If you have seen other doctors since your illness or injury began, list their names, addresses, dates and reasons for visits in Part VI.

8. Have you been hospitalized or treated at a clinic for your illness of injury? ..... ☐ Yes ☐ No
If "Yes," show the following:

NAME OF HOSPITAL OR CLINIC	ADDRESS	
PATIENT OR CLINIC NUMBER		
WERE YOU AN INPATIENT? (STAYED AT LEAST OVERNIGHT) ☐ Yes ☐ No IF "Yes," SHOW →	DATES OF ADMISSIONS	DATES OF DISCHARGES
WERE YOU AN OUTPATIENT? ☐ Yes ☐ No IF "Yes," SHOW →	DATES OF VISITS	

REASON FOR HOSPITALIZATION OR CLINIC VISITS

TYPE OF TREATMENT RECEIVED

If you have been in other hospitals or clinics for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization or clinic visits in Part VI.

9. Have you been seen by other agencies for your injury or illness? ..... ☐ Yes ☐ No
(VA, Workmen's Compensation, Vocational Rehabilitation, Welfare, etc.)
If "Yes," show the following:

NAME OF AGENCY	ADDRESS OF AGENCY
YOUR CLAIM NUMBER	

DATES OF VISITS

TYPE OF TREATMENT OR EXAMINATION RECEIVED

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part VI.

PART III — INFORMATION ABOUT YOUR ACTIVITIES

10. Has any doctor told you to cut back or limit your activities in any way? ☐ Yes ☐ No

If "Yes," give the name of the doctor below and tell what he or she told you about cutting back or limiting your activities:

11. Describe your daily activities in the following areas and state what and how much you do of each and how often you do it.

- Household maintenance (including cooking, cleaning, shopping, and odd jobs around the house as well as any other similar activities):

- Recreational activities and hobbies (hunting, fishing, bowling, hiking, musical instruments, etc.):

- Social contacts (visits with friends, relatives, neighbors):

- Other (drive car, motorcycle, ride bus, etc.):

PART IV — INFORMATION ABOUT YOUR EDUCATION

12. What is the highest grade of school that you completed?

13. Have you gone to trade or vocational school or had any other type of special training? ☐ Yes ☐ No

If "Yes," show:

- The type of trade or vocational school or training:
- Approximate dates you attended:
- How this schooling or training was used in any work you did:

PART V — INFORMATION ABOUT THE WORK YOU DID

14. A. If you did work, what was your usual job in the 15 years before you became disabled. *(Normally, this will be the kind of work you did for the longest period of time.)* Include the type of business (for example, farming, restaurant, etc.)

B. Describe your duties in this job. (Show how much bending, lifting, walking, writing, or other activities were required. How often did you lift things, and how heavy were they? What kind of special tools or skills were required? What kind of written reports did you complete? How many people did you supervise, if any?)

15. A. Did your condition make you stop working? ☐ Yes ☐ No

B. If "Yes," what is the date you stopped working? MONTH, DAY, YEAR

C. If this date is different from the one shown in Item 1B (the date you say you became disabled), explain the reason for the difference:

PART VI — REMARKS

Use this additional space to answer any previous questions and to provide any additional information that you think will be helpful in making a decision in your disability claim. Please refer to the previous items by number.

(Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)

SIGN HERE

DATE

PART VII - FOR SSA USE ONLY — DO NOT WRITE BELOW THIS LINE

Name of Claimant	Social Security Number

16. Check any of the following categories which apply to this case:

A. PRESUMPTIVE DISABILITY CONSIDERATION
(If any of these boxes are checked, DO's (and DDS's) should be alert to the possibility of a presumptive disability determination in SSI claims per CM 12782 and DISM 545).

1. ☐ Amputation of two limbs
2. ☐ Amputation of a leg at the hip
3. ☐ Allegation of total deafness
4. ☐ Allegation of total blindness
5. ☐ Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, allegedly due to a longstanding condition — exclude recent accident and recent surgery.
6. ☐ Allegation of a stroke (cerebral vascular accident) more than four months in the past and continued marked difficulty in walking or using a hand or arm.
7. ☐ Allegation of cerebral palsy, muscular dystrophy or muscular atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of the hands or arms.
8. ☐ Allegation of diabetes with amputation of a foot.
9. ☐ Allegation of Down's Syndrome (Mongolism)
10. ☐ An applicant filing on behalf of another individual alleges severe mental deficiency for claimant who is at least 7 years of age. The applicant alleges that the individual attends (or attended) a special school, or special classes in school, because of his mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities.

B. SUBSTANTIAL GAINFUL ACTIVITY CONSIDERATION
(If this box is checked, be sure to secure an SSA-821 or SSA-821B regarding work activity.)

☐ Claimant is now working

17. A. Does the claimant need assistance in prosecuting his or her claim? ☐ Yes ☐ No

If "Yes," show name, address, relationship, and telephone number of an interested party willing to assist the claimant.

B. [illegible] ☐ Yes ☐ No

18. A. Check each item to indicate if any difficulty was observed:

Reading:	☐ Yes	☐ No	Using Hands:	☐ Yes	☐ No
Writing:	☐ Yes	☐ No	Breathing:	☐ Yes	☐ No
Answering:	☐ Yes	☐ No	Seeing:	☐ Yes	☐ No
Hearing:	☐ Yes	☐ No	Walking:	☐ Yes	☐ No
Sitting:	☐ Yes	☐ No			
Understanding:	☐ Yes	☐ No	Other *(Specify)*: _____		

B. If any of the above items were checked "Yes," describe the exact difficulty involved:

C. Describe the claimant fully (e.g., general build, height, weight, behavior, any difficulties that add to or supplement those noted above, etc.):

19. Does the claimant speak English? ..... ☐ Yes ☐ No
If "No," what language does he speak?

20. Medical Development — Initiated by District or Branch Office.

SOURCE	DATE REQUESTED	DATE(S) OF FOLLOW-UP	CAPABILITY DEVELOPMENT REQUESTED

21. Is capability development by the DDS necessary? ..... ☐ Yes ☐ No

22. Is development of work activity necessary? ..... ☐ Yes ☐ No

If "Yes," is an SSA-821 or SSA-821 B ..... ☐ Pending ☐ In File

23. SSA-3368 Taken By
☐ Personal Interview
☐ Telephone ☐ Mail

24. Form Supplemented: ☐ Yes ☐ No
If "Yes," by
☐ Personal Interview ☐ Telephone ☐ Mail

Signature of DDS or SO Interviewer or Reviewer	Title	Date

Form SSA-3368-F4

☆U.S. GOVERNMENT PRINTING OFFICE: 1992-361-165/671

2. Vocational Report

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0141

VOCATIONAL REPORT

This report supplements the Disability Report (Form SSA-3368) by requesting additional information about your past work experience. PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

Privacy Act Notice: The information requested on this form is authorized by Title 20 CFR 404.1523 and Title 20 CFR 416.923. The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to social security programs and to comply with Federal laws requiring the exchange of information between Social Security and another agency.

A. Name of Claimant	B. Social Security Number	C. Telephone number where you can be reached:

PART I — INFORMATION ABOUT YOUR WORK HISTORY

1. List the job or jobs you have had in the last 15 years before you stopped working. (If you have a 6th grade education or less, AND performed only heavy unskilled labor for 35 years or more, list the job or jobs you have had *since you began to work. If you need more space, use Part III.)*

	JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (Month and Year)		DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
			FROM	TO		
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

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PART II — INFORMATION ABOUT YOUR JOB DUTIES

2. Provide the following information (on pages 2-5) for each of the jobs listed in Part I starting with your usual job. Note: If you listed just one job in Part I, complete only page 2.

Job Title (from Part I):

A. In your job did you:

- Use machines, tools, or equipment of any kind? ☐ Yes ☐ No
- Use technical knowledge or skills? ☐ Yes ☐ No
- Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No
- Have supervisory responsibilities? ☐ Yes ☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) — 0 1 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) — 0 1 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) — 0 1 2 3 4 5 6 7 8
- **Bending** (circle how often a day you had to bend) — Never - Occasionally - Frequently - Constantly
- **Reaching** (circle how often a day you had to reach) — Never - Occasionally - Frequently - Constantly
- **Lifting and Carrying** Describe below what kind of objects or material was lifted, how much it weighed, how many times a day you lifted this material, and how far you carried it:

Job Title (from Part I):

A. In your job did you:

- Use machines, tools, or equipment of any kind? ☐ Yes ☐ No
- Use technical knowledge or skills? ☐ Yes ☐ No
- Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No
- Have supervisory responsibilities? ☐ Yes ☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) — 0 1 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) — 0 1 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) — 0 1 2 3 4 5 6 7 8
- **Bending** (circle how often a day you had to bend) — Never - Occasionally - Frequently - Constantly
- **Reaching** (circle how often a day you had to reach) — Never - Occasionally - Frequently - Constantly
- **Lifting and Carrying:** Describe below what kind of objects or material was lifted, how much it weighed, how many times a day you lifted this material, and how far you carried it:

Job Title (from Part I):

A. In your job did you:

- Use machines, tools, or equipment of any kind? ☐ Yes ☐ No
- Use technical knowledge or skills? ☐ Yes ☐ No
- Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No
- Have supervisory responsibilities? ☐ Yes ☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) — 0 1 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) — 0 1 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) — 0 1 2 3 4 5 6 7 8
- **Bending** (circle how often a day you had to bend) — Never - Occasionally - Frequently - Constantly
- **Reaching** (circle how often a day you had to reach) — Never - Occasionally - Frequently - Constantly
- **Lifting and Carrying:** Describe below what kind of objects or material was lifted, how much it weighed, how many times a day you lifted this material, and how far you carried it:

Job Title (from Part I):

A. In your job did you:
- Use machines, tools, or equipment of any kind? ☐ Yes ☐ No
- Use technical knowledge or skills? ☐ Yes ☐ No
- Do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No
- Have supervisory responsibilities? ☐ Yes ☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision.

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) — 0 1 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) — 0 1 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) — 0 1 2 3 4 5 6 7 8
- **Bending** (circle how often a day you had to bend) — Never - Occasionally - Frequently - Constantly
- **Reaching** (circle how often a day you had to reach) — Never - Occasionally - Frequently - Constantly
- **Lifting and Carrying:** Describe below what kind of objects or material was lifted, how much it weighed, how many times a day you lifted this material, and how far you carried it:

IF YOU NEED ADDITIONAL SPACE TO PROVIDE INFORMATION ABOUT OTHER JOBS LISTED IN PART I OF THIS FORM, USE PART III OR ASK THE SOCIAL SECURITY OFFICE FOR ADDITIONAL COPIES OF THIS FORM.

PART III — REMARKS

Use this section for any other information you may want to give about your work history, or to provide any other remarks you may want to make to support your disability claim:

(If you need more space, use separate sheets of paper.)

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)

SIGN HERE ▶ _____ DATE _____

Do not write below this line

SSA-3369 TAKEN BY ☐ PERSONAL INTERVIEW ☐ TELEPHONE ☐ MAIL	FORM SUPPLEMENTED: ☐ YES ☐ NO If "Yes," by ☐ PERSONAL INTERVIEW ☐ TELEPHONE ☐ MAIL
SIGNATURE OF INTERVIEWER OR REVIEWER	TITLE *(also check office)* ☐ DDS ☐ DO ☐ BO DATE

Form SSA-3369-F6 (5-79)

3. Report of Continuing Disability Interview

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0072

REPORT OF CONTINUING DISABILITY INTERVIEW
(Write Legibly)

OFFICE	DATE
REPORT MADE ☐ IN PERSON ☐ TELEPHONE	PLACE OF REPORT ☐ DO ☐ HOME ☐ CONTACT STATION ☐ OTHER

SOCIAL SECURITY NUMBER	WAGE EARNER	BENEFICIARY'S NAME IF NOT THE WAGE EARNERS

PERSON REPORTING:

☐ BENEFICIARY

☐ OTHER PERSON *(Show name, address, relationship and why beneficiary is not reporting)*

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 89-97

I understand that this report will be used to determine whether to continue or to stop my disability case benefits. I also understand that if I am receiving social security disability benefits and supplemental security income payments, this questionnaire is applicable to both claims.

Note: This information must reflect the beneficiary's *(or his/her representative's)* statements regarding the disabling condition since the last interview, i.e., the initial disability application or continuing disability investigation. This report will be one of the criteria in verifying continuing eligibility to disability benefits. If, after completion of the investigation, it is determined that there no longer is a disabling condition, benefits will be terminated.

1. MEDICAL CARE AND TREATMENT

(a) Have you been examined, treated, or hospitalized since you last reported such information about your disability? ☐ Yes If "Yes" complete item below. ☐ No

NAME, ADDRESS, AND PHONE NUMBER OF PHYSICIAN, HOSPITAL OR CLINIC	DATES WHEN EXAMINED OR TREATED

(b) Were there times when you were confined to your home? ☐ Yes ☐ No
If "Yes", give dates and reasons.

(c) Are you attending school? (Answer only if you are receiving childhood disability payments.)

☐ Yes ☐ No If yes, give name and address of school and current grade.

Form SSA-454 F4 (5/82)
Prior editions may be used until exhausted

96-297 O—82——17

2. DAILY ACTIVITIES

Make a check mark in front of any of the following activities you have difficulty or a need for assistance in doing. (Explain in the space at the end of the list what the difficulty or the need for assistance is.)

- ☐ WALKING, MOVING ABOUT, OR EXERCISING YOUR LEGS
- ☐ EATING, INCLUDING CHEWING, DIGESTING, ETC.
- ☐ BATHING, GETTING IN AND OUT OF TUB, REACHING, ETC.
- ☐ DRESSING, TYING SHOES, COMBING HAIR, ETC
- ☐ TAKING CARE OF ALL PERSONAL NEEDS
- ☐ PERFORMING HOUSEHOLD CHORES
- ☐ GARDENING, A YARD OR LAWN WORK
- ☐ DRIVING A MOTOR VEHICLE
- ☐ USING PUBLIC TRANSPORTATION
- ☐ ENGAGING IN SOCIAL ACTIVITIES
- ☐ TALKING TO AND DEALING WITH OTHER PEOPLE
- ☐ ENGAGING IN HOBBIES OR PASTIMES

EXPLANATION:

3. CHANGES IN CONDITION

(a) Do you feel your medical condition has improved so that you are able to return to work?
☐ Yes *(If yes, explain and describe any limitations in item 6.)*
☐ No *(If no, explain in item 6.)*

(b) Has your doctor told you that you are able to return to work?
☐ Yes *(If Yes, answer items c, d, and e below.)* ☐ No ☐ Did not say

(c) List the name and address of the doctor(s) who told you to return to work.

(d) What date did your doctor tell you to return to work? Date

(e) Did the doctor restrict you to limited or part-time work?
☐ Yes *(If yes, explain in item VI.)* ☐ No

4. EFFORTS TO WORK

(a) Since you became disabled, if you have engaged in any work activity that has not been previously reported, explain below.

(b) If you received any additional renumeration from an employer *(such as sick pay, vacation pay, bonuses, commissions, etc.)* that have not previously been explained in the file, explain below.

5. VOCATIONAL REHABILITATION

IMPORTANT: Even if it is determined that you are not disabled, you may be eligible for continued payments if you are in an approved State vocational rehabilitation program.

(a) Are you receiving help, such as services, training or counseling from the State vocational rehabilitation agency?

Yes ☐ No ☐ *If yes, complete the following*

(b) What kind of help have you received, or do you expect to receive, and when?

(c) What is the name and address of your VR counselor?

6. ADDITIONAL COMMENTS

After reading the above report and knowing that anyone making a false statement or false representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law, I certify that the above statements are true.

Signature and Address *Date*

7. OBSERVATIONS — FOR SSA USE ONLY

(a) Indicate whether or not you observed any difficulty with:

	NO	YES		NO	YES
Breathing	☐	☐	Use of Hands & Arms	☐	☐
Sight	☐	☐	Writing	☐	☐
Speaking	☐	☐	Reading	☐	☐
Hearing	☐	☐	Comprehending	☐	☐
Sitting	☐	☐	Responding	☐	☐
Walking	☐	☐	Relating to People	☐	☐
Standing	☐	☐			

(b) Describe fully whatever difficulty was observed in any item marked "Yes". Also comment on the beneficiary's general appearance, behavior and other circumstances surrounding the interview.

SIGNATURE & TITLE OF SSA INTERVIEWER OR RECEIVER' | DATE

APPENDIX D: TABULAR DATA

TABLE 35.—OASDHI BENEFICIARIES, STATE BY STATE, 1980

[Number of monthly benefits in current-payment status, by type of beneficiary and by State, at end of June 1980]

State [1]	Total [2]	Retired workers [3]	Disabled workers [4]	Wives and husbands [5] of—		Children [6] of—			Widowed mothers and fathers [7]	Widows and widowers [8]	Parents [9]	Special age-72 beneficiaries
				Retired workers	Disabled workers	Retired workers	Deceased workers	Disabled workers				
Total	35,219,930	19,167,531	2,862,919	2,986,813	467,560	632,762	2,668,216	1,403,175	560,303	4,354,184	15,329	101,138
Alabama	636,923	294,320	61,057	57,209	11,443	16,032	62,145	32,474	13,633	87,018	541	1,051
Alaska	20,880	9,323	1,614	1,162	244	820	4,398	1,008	826	1,435	9	14
Arizona	414,688	236,579	33,448	37,628	5,715	7,456	31,108	15,712	6,397	39,782	139	724
Arkansas	438,479	217,162	44,219	42,794	8,443	9,765	30,667	23,403	6,331	54,321	204	1,170
California	3,179,084	1,800,002	287,191	256,322	37,277	55,188	224,095	119,080	44,250	344,982	804	9,893
Colorado	327,514	179,634	24,062	31,105	3,747	4,604	26,789	11,219	5,356	39,824	73	1,101
Connecticut	472,490	293,890	30,428	32,236	3,825	6,486	30,116	12,272	6,189	55,086	136	1,826
Delaware	86,115	47,527	7,373	6,070	1,033	1,315	7,281	3,306	1,528	10,438	29	215
Dist. of Col	87,690	49,936	7,458	4,832	534	1,518	8,984	2,311	1,664	9,996	49	408
Florida	2,038,867	1,248,196	149,450	182,668	23,045	26,849	105,327	61,281	22,661	214,420	523	4,447
Georgia	764,043	363,851	86,151	52,283	13,666	13,851	80,122	44,351	16,587	90,571	505	2,105
Hawaii	111,003	62,094	6,984	9,779	1,049	7,056	8,990	3,445	2,020	9,192	68	326
Idaho	130,046	74,511	8,936	12,762	1,449	2,319	9,856	4,113	1,776	13,933	18	373
Illinois	1,620,344	924,049	109,574	127,796	14,444	24,089	130,487	47,751	26,258	209,808	660	5,428
Indiana	811,096	449,681	61,540	67,037	9,473	11,923	62,215	29,642	12,455	104,991	243	1,896
Iowa	489,191	281,153	26,954	53,817	3,998	6,846	28,234	11,359	5,391	68,783	87	2,569
Kansas	372,822	218,597	20,602	38,606	2,785	4,889	22,117	8,419	4,089	50,729	75	1,914
Kentucky	594,936	275,179	57,744	58,891	13,764	12,109	47,641	35,034	11,063	81,982	288	1,241
Louisiana	578,705	242,405	58,036	54,930	13,407	12,546	60,544	38,275	13,724	82,549	280	2,009
Maine	196,631	111,930	15,163	15,943	2,701	3,095	12,850	7,851	2,765	23,744	63	526
Maryland	525,682	290,711	40,469	38,257	5,180	8,182	47,441	16,145	9,584	67,549	247	1,917
Massachusetts	918,712	558,545	60,877	63,880	9,248	12,112	58,965	27,040	13,057	111,725	252	3,011
Michigan	1,349,424	709,892	113,022	115,495	18,035	23,347	111,997	55,793	22,570	175,881	464	2,928
Minnesota	612,321	358,859	31,491	63,871	4,780	11,094	38,925	14,094	7,420	78,750	102	2,935
Mississippi	426,810	192,887	44,286	35,631	8,260	13,232	43,468	26,853	8,974	51,985	327	907
Missouri	854,098	477,029	66,262	75,836	10,550	12,806	57,059	31,098	11,618	109,161	228	2,451
Montana	118,007	64,557	8,521	11,240	1,463	2,165	9,624	4,210	1,725	14,012	35	455
Nebraska	253,237	148,237	13,375	27,087	1,903	3,366	15,606	5,927	2,931	33,326	53	1,426

TABLE 35.—OASDHI BENEFICIARIES, STATE BY STATE, 1980—Continued

[Number of monthly benefits in current-payment status, by type of beneficiary and by State, at end of June 1980]

State [1]	Total [2]	Retired workers [3]	Disabled workers [4]	Wives and husbands [5] of—		Children [6] of—			Widowed mothers and fathers [7]	Widows and widowers [8]	Parents [9]	Special age-72 beneficiaries
				Retired workers	Disabled workers	Retired workers	Deceased workers	Disabled workers				
Nevada	92,333	53,702	8,478	6,052	1,040	1,433	8,273	3,194	1,678	8,321	17	145
New Hampshire	138,535	86,441	9,137	9,468	1,377	1,877	8,992	4,152	1,856	14,715	18	502
New Jersey	1,151,500	673,159	91,842	77,907	12,554	15,231	80,770	38,455	17,961	140,279	477	2,865
New Mexico	172,564	82,531	14,596	16,373	3,629	4,456	18,139	10,636	4,118	17,563	124	399
New York	2,862,307	1,662,389	232,232	192,716	34,295	46,197	197,087	107,241	41,067	338,827	1,126	9,130
North Carolina	887,467	454,907	89,335	64,241	13,171	15,481	83,829	39,093	17,304	107,420	587	2,099
North Dakota	104,346	57,459	4,917	13,461	869	2,339	6,921	2,455	1,338	14,099	25	463
Ohio	1,611,006	837,806	132,036	148,767	21,682	23,822	121,616	63,584	25,423	231,260	496	4,514
Oklahoma	476,212	254,654	37,856	47,586	6,376	6,985	32,362	17,828	6,488	64,601	168	1,308
Oregon	406,639	244,966	30,123	34,608	4,243	6,031	25,362	12,020	4,619	43,525	85	1,057
Pennsylvania	2,052,847	1,144,788	158,565	175,944	24,189	26,729	132,220	61,759	30,508	291,273	850	6,022
Rhode Island	168,213	103,216	14,103	9,679	1,895	1,894	10,002	5,558	2,220	19,055	44	547
South Carolina	443,333	212,591	50,075	27,923	7,688	8,293	50,182	23,514	10,893	50,798	345	1,031
South Dakota	118,438	66,125	6,287	13,554	1,042	2,162	8,014	2,796	1,575	16,271	16	596
Tennessee	730,591	359,750	72,925	65,289	12,562	14,345	59,574	36,188	12,867	94,598	469	2,024
Texas	1,799,293	912,303	131,071	180,974	24,237	36,993	162,099	70,340	35,400	240,429	925	4,522
Utah	145,738	82,842	8,757	14,142	1,403	2,665	13,088	4,322	2,418	15,788	24	289
Vermont	80,073	45,270	6,276	6,613	1,046	1,209	5,356	3,083	1,120	9,799	21	280
Virginia	712,313	363,852	66,074	56,022	11,412	12,885	62,917	31,782	13,360	91,155	433	2,421
Washington	574,855	339,106	41,880	48,912	5,828	8,889	39,181	17,710	6,822	64,688	109	1,730
West Virginia	358,438	153,816	38,207	35,573	9,781	8,107	27,345	22,903	6,717	54,881	214	894
Wisconsin	761,058	444,594	47,819	70,562	7,386	12,858	47,740	22,856	9,252	94,988	146	2,857
Wyoming	48,981	28,383	2,728	4,400	391	756	4,390	1,234	777	5,750	15	157
Other areas:												
A. Samoa	2,394	415	123	212	78	476	593	283	144	64	6	0
Guam	3,013	860	180	293	52	277	809	191	199	147	5	0
Puerto Rico	568,427	177,755	81,266	51,814	24,782	36,733	49,441	97,624	11,287	36,750	961	0
Virgin Islands	7,578	3,439	460	590	94	560	1,349	366	249	454	17	0

Abroad.....	311,600	139,676	9,257	37,971	2,997	18,019	33,514	8,542	9,801	50,713	1,104	0

[1] Beneficiary by State of residence.

[2] At the end of 1980 an estimated 40,000 Railroad Retirement beneficiaries would have been eligible for social security benefits had they applied. These persons receive their Social Security benefits as part of their Railroad Retirement annuity and are not included in the above tabulations. Of these 40,000 beneficiaries, 19,000 were retired workers, 5,500 were disabled workers, and 15,500 were spouses and children.

[3] Aged 62 and over.

[4] Under age 65.

[5] Includes wife beneficiaries aged 62 and over, nondivorced and divorced, and those under age 65 with entitled children in their care.

[6] Includes disabled persons aged 18 and over whose disability began before age 22 and entitled full-time students aged 18–21.

[7] Includes surviving divorced mothers and fathers with entitled children in their care.

[8] Aged 60 and over for widows, widowers, and surviving divorced wives, and aged 62 and over for parents. Also includes disabled widows, widowers, and surviving divorced wives aged 50–59.

Source: Social Security Bulletin, June 1982, Vol. 45, No. 6.

TABLE 36.—DISTRIBUTION OF DISABLED-WORKER BENEFICIARIES BY EDUCATION AND OCCUPATION, COMPARED WITH ADULT U.S. POPULATION, 1975

Education and occupation	Year allowed benefits—1975	Adult U.S. population [1]
Total percent	100	100
Education (years of school completed):		
No schooling	1	2
Elementary school (1 to 8)	37	27
High school	52	51
9 to 11	24	19
12	28	31
Some college	10	21
Occupation:		
Professional, technical and managerial	18	24
Clerical and sales	14	25
Service	17	12
Farming	4	3
Transportation, packaging and handling, mineral extraction	12	18
Machine trades	10	
Bench work	7	18
Processing	3	
Structural work	15	

[1] Derived from 1970 Census figures for education based on persons aged 25 and over. Figures for occupation based on employed population aged 18–64.

Source: Background material and data on major programs within the jurisdiction of the Committee on Ways and Means, Ways and Means Committee Print 97–29, February 18, 1982.

TABLE 37.—AMOUNT AND SOURCE OF INCOME FROM VARIOUS SOURCES FOR DISABLED-WORKER [1] FAMILIES, 1975

Source of family income	Own benefit less than $3,000			Own benefit $3,000 or more		
	Percent with income from source	Average income from source for—		Percent with income from source	Average income from source for—	
		Those with such income	Average recipient		Those with such income	Average recipient
Social Security	100.0	$2,584	$2,584	100.0	$5,356	$5,356
SSI	27.0	1,111	300	10.3	882	91
Public assistance	29.2	1,753	512	13.8	1,727	238
Veterans' benefits	17.2	1,945	335	21.4	3,374	722
Workmen's compensation	8.3	4,170	346	7.3	2,358	172
Property income	23.8	480	114	34.3	1,038	356
Public or private pension	11.1	3,035	337	19.3	3,705	715
Earnings	73.4	6,168	4,527	66.7	5,897	3,921

TABLE 37.—AMOUNT AND SOURCE OF INCOME FROM VARIOUS SOURCES FOR DISABLED-WORKER [1] FAMILIES, 1975—Continued

Source of family income	Own benefit less than $3,000			Own benefit $3,000 or more		
	Percent with income from source	Average income from source for—		Percent with income from source	Average income from source for—	
		Those with such income	Average recipient		Those with such income	Average recipient
Other	5.2	1,172	61	10.8	1,846	199
Total family income			9,380			11,947
Food stamps	34.5			20.6		
Average years of school completed by disabled worker	8			10		

[1] Refers to men 21 to 62 years of age in March 1976, who reported a disability limiting work activity and receipt of social security benefits in 1975.

Source: Based on Survey of Income and Education, U.S. Bureau of the Census.

TABLE 38.—ANNUAL DISPOSABLE INCOME OF DISABLED-WORKER BENEFICIARY FAMILIES BEFORE AND AFTER DISABILITY, BY SEX OF DISABLED WORKER (PROJECTED TO 1980)

	Percentage distribution of DI families	Predisability disposable income [1]	Postdisability disposable income [2]	Ratio: Post-disability disposable income to predisability disposable income
Families where spouse has earnings:				
Men	37	$14,493	$15,407	1.06
Under 40	6	13,035	14,141	1.08
40 to 54	19	15,112	15,936	1.05
55 to 64	12	14,386	15,148	1.05
Women	17	17,196	18,509	1.08
Under 40	7	17,151	18,768	1.09
40 to 54	7	18,147	19,400	1.07
55 to 64	3	(3)	(3)	(3)
Families where spouse does not have earnings:				
Men	37	10,822	10,293	.95
Under 40	6	9,768	10,392	1.06
40 to 54	20	11,221	10,427	.93
55 to 64	11	10,938	10,049	.92

TABLE 38.—ANNUAL DISPOSABLE INCOME OF DISABLED-WORKER BENEFICIARY FAMILIES BEFORE AND AFTER DISABILITY, BY SEX OF DISABLED WORKER (PROJECTED TO 1980)—Continued

	Percentage distribution of DI families	Predisability disposable income [1]	Postdisability disposable income [2]	Ratio: Post-disability disposable income to predisability disposable income
Women	9	6,938	7,260	1.05
Under 40	2	([3])	([3])	([3])
40 to 54	5	6,493	6,650	1.02
55 to 64	2	([3])	([3])	([3])
Total	100			

[1] Includes estimated earnings of worker and spouse, property income and transfer payments. Taxable income adjusted for estimated taxes and 6 percent of earned income is deducted for work expenses.

[2] Includes estimated earnings of spouse, property income, social security benefits and transfer payments. Taxable income is adjusted for taxes and 6 percent of earned income is deducted for work expenses.

[3] Sample size too small for reliable estimate.

Source: Estimated in 1979, prior to 1980 amendments, based on matched tape of CPS, social security records and longitudinal earnings records.

XI. GLOSSARY OF TERMS

Administrative Law Judge (ALJ).—An experienced attorney who has received training in adjudicating disability claims. The ALJ is responsible for perfecting the evidentiary record, holding face-to-face nonadversary hearings and issuing decisions. An ALJ hearing is the third stage in the disability determination process (after the initial State agency decision and reconsideration).

Affirmed.—A decision to uphold a disability determination reached at a lower adjudication level.

Allowance.—A determination that a worker is entitled to a cash disability benefit because of an inability to work by reason of a physical or mental impairment.

Appeals Council.—The Appeals Council is a 15-member body located in the Office of Hearings and Appeals of the Social Security Administration. The Appeals Council review of a disability case represents the Secretary's final decision and is the last administrative remedy.

Bellmon Report.—The 1980 Disability Amendments included an amendment offered by Senator Bellmon which required the Department of Health and Human Services to institute a program of review of administrative law judge decisions. The amendment also required a report on the progress in implementing this review program and on various factors related to administrative law judge reversals of State agency decisions. This report (printed in an appendix of this document) is referred to as the Bellmon Report.

Cessation.—A determination that a beneficiary who has been under a disability within the meaning of the law is no longer under such disability.

Consultative Examination (CE).—A consultative examination is an examination purchased at the Federal Government's expense from the attending physician or an independent source for cases requiring medical information to supplement the medical evidence of record.

Continuance.—A determination that a person who has been under a disability within the meaning of the law is still under such disability.

Continuing Disability Investigation (CDI).—A review of the continuing eligibility of an individual currently receiving disability benefits. Minimum requirements on the rate of review were mandated in the Disability Amendments of 1980 (see *Periodic Review*).

Denial.—A determination that a worker is not entitled to cash disability benefits.

Disability Determination Service (DDS).—A State agency, usually a component of the State's vocational rehabilitation agency, which (1) makes the initial determination as to whether an individual is disabled, (2) reconsiders initial decisions if the claimant believes he has been wrongfully denied, and (3) conducts continuing disability

investigations to determine whether individuals should remain on the disability rolls.

Disability Insured Status.—To qualify for DI benefits an individual must meet certain insured status requirements. Workers who are disabled after age 31 must have credit for having worked in covered employment for 5 out of the last 10 years prior to their disability; for workers under age 25, the minimum requirement is 1½ years of work out of the 3 years prior to disability; for workers age 25 through 31, progressively more years of coverage are required. The individual must also be "fully insured" to be eligible for DI benefits.

Fully Insured Status.—To qualify for DI benefits, an individual must have credit for having worked in covered employment one quarter for each year after 1950 or, if later, the year he attains age 21 and prior to the onset of disability. The individual must also be "disability insured."

Medical Diary.—A system used by State disability determination services for selecting and scheduling certain kinds of disability cases for future medical examinations. In general, cases are to be "diaried" for medical reexamination only if the impairment is one of 17 specifically listed impairments considered likely to improve.

Medical Listings of Impairments.—Medical criteria published in the regulations which describe specific diagnostic signs, symptoms and clinical laboratory findings for various common impairments which are considered severe enough to ordinarily prevent a person from doing any gainful activity on a sustained basis.

Own Motion Review.—The procedure whereby the Social Security Administration Appeals Council decides to review an ALJ action on its own authority. Own-motion review was mandated by the Disability Amendments of 1980,

Periodic Review.—As mandated by the Disability Amendments of 1980, SSA is required to reexamine, at least once every 3 years, the continuing eligibility of beneficiaries whose disabilities have not been determined to be permanent. Beneficiaries with permanent disabilities must be reviewed periodically but the Secretary has the discretion to determine the frequency of reviews.

Posteffectuation Review.—A review of disability cases made after the claimant has been notified of the decision regarding the payment of benefits.

Pre-effectuation Review.—A review of disability allowances or denials in which incorrect decisions made by State disability determination services are reversed prior to notification of the claimant or payments of any benefits. Preeffectuation review requirements were mandated by the Disability Amendments of 1980.

Program Operating Manual System (POMS).—The POMS is a detailed set of administrative instructions which amplify the law, regulations and Social Security rulings. These guidelines set forth the objectives and requirements of the disability program and furnish specific standards and procedures with which the State disability determination services must comply in reaching a disability determination. The POMS is binding on State agencies, but not on ALJ's.

Reconsideration.—Individuals whose applications are denied or whose benefits are terminated by the State disability determination services (DDS) have a right to have their claims reconsidered. A request for reconsideration must be filed within 60 days after receiving notice of the denial. The reconsideration decision is also made by the State DDS.

Residual Functional Capacity (RFC).—An assessment of an individual's physical and mental ability to perform various types of work-related functions despite his impairment.

Reversal.—A appellate decision to change a disability determination reached at a lower level of adjudication. This term is most frequently used to refer to ALJ allowances of claims denied (or terminated) by the State DDS.

Social Security Rulings (SSR).—Social security rulings amplify SSA's policies and provide interpretations of the Act and regulations. Rulings are based on case decisions, program policy statements, decisions of the ALJ's and Appeals Council, opinions of the Secretary's Office of the General Counsel, Social Security Commissioner's decisions, Federal court decisions, and other interpretations of the law and regulations. They are binding on the State agencies and ALJ's.

Substantial Gainful Activity (SGA).—The part of the definition of disability which precludes entitlement to DI or SSI disability benefits when an impaired individual engages in substantial paid work; "substantial" is measured by the amount of wages the worker earns (currently pegged at $300 or more per month).

Vocational Grid.—Three tables published in regulations which relate the requirements of jobs that exist in the national economy with the vocational factors of age, education, and prior work experience. These tables provide a guide to decision-makers in determining whether workers with certain physical and mental capacities can meet the demands of jobs that exist in significant numbers in the national economy.

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